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The Ohio comprehensive statewide study of vocational rehabilitation is reported. Attention is given to the study's philosophy and development as well as to Ohio's rehabilitation needs, program potential, variables affecting programs, and criteria for establishing priorities. Recommendations reviewed regard the state's Rehabilitation Services Commission, service and facility network, information network, organizational support, program planning committee, and legislation and finance committee. Further recommendations treat establishment of conditions to facilitate delivery of services, provision of services, disabilities of clients needing services, and categories of services. Supportive data concerning the study setting, Ohioans in need of services, and assessment of state agencies are cited; the study procedure is detailed in terms of organizational structure, purpose and design, interstate and state research components, study activities, public relations, time table and critical path, and implementation. (JD)

ED0 32677

REPORT OF THE

GOVERNOR'S COUNCIL ON VOCATIONAL REHABILITATION

OHIO COMPREHENSIVE STATEWIDE PLANNING

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HOPE, THE ANCHOR OF LIFE

September 1, 1968

FINAL REPORT OF THE GOVERNOR'S COUNCIL

OHIO COMPREHENSIVE STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

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Inclusive Period of Planning Project
July 1, 1966 -- September 30, 1968

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Comprehensive Statewide Planning
James A. Rhodes
Governor

June 30, 1968

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Honorable James A. Rhodes
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State Capital Building
Columbus, Ohio 43215

Dear Governor Rhodes:

It is with a sense of satisfaction and accomplishment that, on behalf of the Governor's Council on Vocational Rehabilitation, I hereby submit to you the final report on Comprehensive Statewide Planning for Vocational Rehabilitation Services in Ohio.

The contents reflect the great contributions of time, talent, and efforts made by over 700 leading citizens of Ohio so that the disabled citizens of our state might take their rightful place as independent, contributing members of society.

The recommendations coming from this study, and the findings which led to them, reflect the great scope and depth of the needs that exist, and the urgency of those actions that must be taken to begin to meet these needs.

It is my hope that the results of this study will receive broad and thorough consideration, and that they will be implemented throughout Ohio by appropriate planning for action to restore the physically, mentally, and socio-economically disabled to personal dignity and social usefulness.

On behalf of all those who have made this study possible, may I express our appreciation for taking part in a work which can provide a better society and a sound economic climate for all of Ohio's citizens.

Sincerely yours,

William H. Eells

William H. Eells
Chairman
Governor's Council on
Vocational Rehabilitation

WHE/pf

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ACKNOWLEDGEMENT

The rehabilitation philosophy itself, a concept and process of comprehensive services to the whole man in context with multiple services - provided the greatest impetus for thoroughness in conducting the two-year Comprehensive Statewide Study of Vocational Rehabilitation.

The dynamic and reasonable self-help characteristics of rehabilitation as a timely approach to current social problems related to growing public dependency rolls, unemployment and poverty created a remarkable growth of interest among the citizens as the Study progressed and was especially evident in the Governor's Council itself.

With this underlying impetus and commitment to the mandate and task, Regional Citizens' Committee Chairmen, Regional Task Force Chairmen and members of the Governor's Council on Vocational Rehabilitation, under the able leadership of Mr. William H. Eells, Council Chairman, provided unique guidance and inspiration for the lay citizens and professionals at all levels of the Study.

Federal Regional Planning Conferences initiated by Mr. Stanley Hedstrom, Regional Associate Commissioner, RSA/HEW were of critical importance in terms of establishing a broad base of comparison with other states, providing consultation on complex problems, and effecting economy through joint projects for study areas of mutual concern among the states in Federal Region V.

The viable base of planning operations established at the outset of the two-year study by Mr. Crayton Walker, Planning Consultant, and supported extensively by Mr. Edward J. Moriarty, Director, Ohio Bureau of Vocational Rehabilitation was in a large measure responsible for the successful completion of the project. The cooperation of Mr. Everett Steece, Chief, Bureau of Services for the Blind, as well as the liberal participation of other executives and professionals in various departments of state government related to rehabilitation was extremely beneficial. BVR-BSB staff at state, regional and district levels contributed substantially to technical and organizational aspects of the Study.

We are indebted to the many other citizens and professional consultants whose contributions to the study resulted in the publishing of the Ohio Governor's Council Report on Vocational Rehabilitation.

Finally, the tedious - yet rewarding detail work supporting the statewide operations of over 700 citizens was carried out with excellence by seven Regional Planning Coordinators and a dedicated Central Office

Planning Staff. We wish to acknowledge the cooperation of Leland McClelland, who served as arts and graphics consultant for the final volume of the report. Special recognition is due Dr. David H. Tait, Associate Project Director for Research, and Miss Marilyn A. Quigley, Executive Assistant, who went far beyond the normal bounds of dedication in providing technical assistance and loyal support.

Robert L. Davis, Project Director
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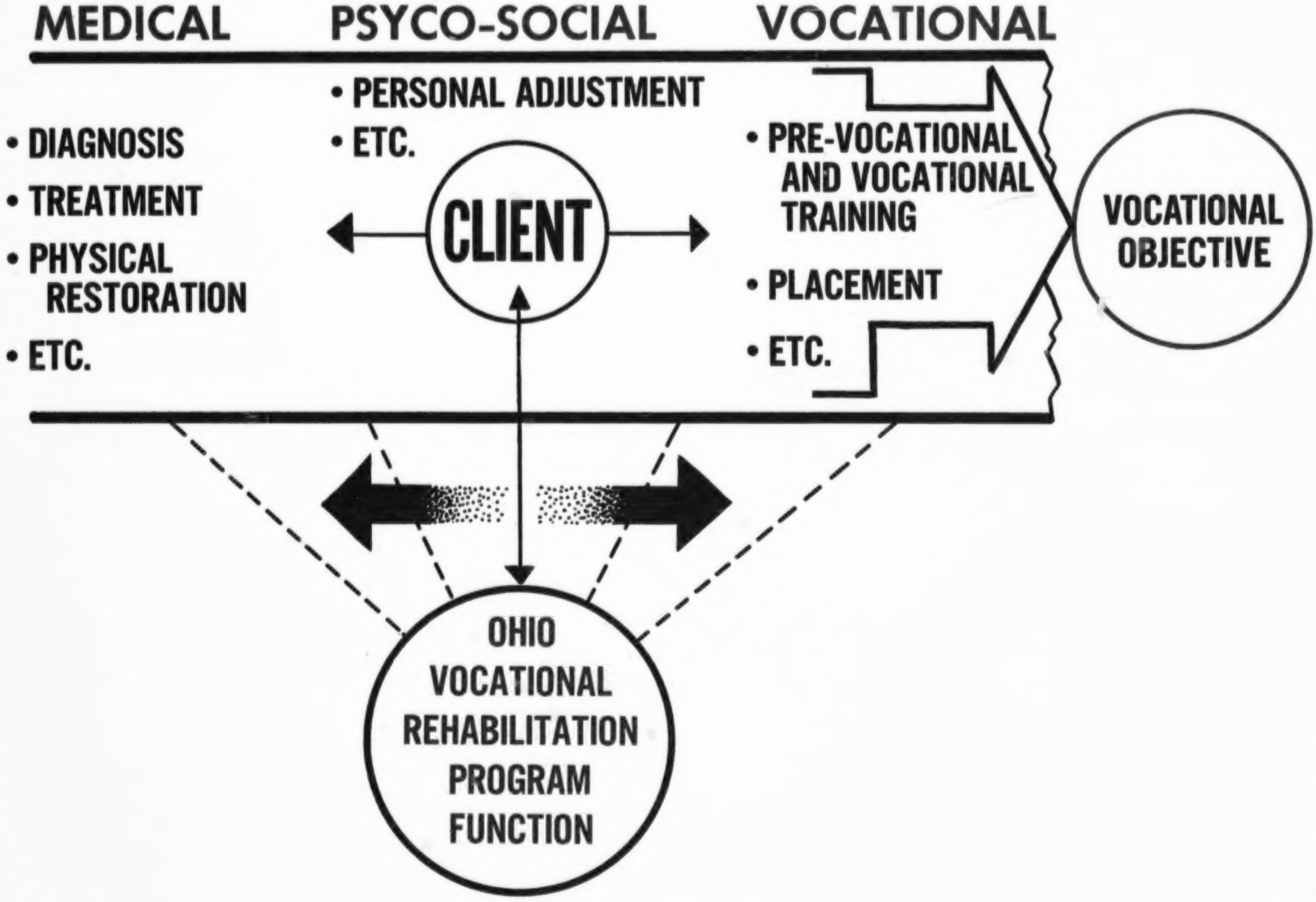
CHAPTER I

STUDY IN PERSPECTIVE

REHABILITATION...
A DYNAMIC CONTINUUM OF SERVICES



MEDICAL

- DIAGNOSIS
- TREATMENT
- PHYSICAL RESTORATION
- ETC.

PSYCO-SOCIAL

- PERSONAL ADJUSTMENT
- ETC.

CLIENT

VOCATIONAL

- PRE-VOCATIONAL AND VOCATIONAL TRAINING
- PLACEMENT
- ETC.

VOCATIONAL OBJECTIVE

OHIO VOCATIONAL REHABILITATION PROGRAM FUNCTION

- FLEXIBLE FUNDING INTO PUBLIC AND PRIVATE AGENCIES
- JOINT PROGRAMMING WITH PUBLIC AND PRIVATE AGENCIES
- COORDINATION OF COMPREHENSIVE SERVICES TOWARD A VOCATIONAL OBJECTIVE

COST BENEFITS / SOCIAL BENEFITS / PERSONAL BENEFITS
1966 RSA / HEW STUDY OF 127,876 REHABILITATED CLIENTS INDICATED:

AVERAGE WAGE OF CLIENT AFTER REHAB--$2837 A YEAR
COMPARED WITH AVERAGE WAGE OF CLIENT BEFORE $491.
+ 3% ANNUAL INCREASE IN PRODUCTION.
$30.50 RETURN ON $1.00 INVESTED IN EACH REHAB (OVER LIFETIME).

FIGURE I

PHILOSOPHY and DEVELOPMENT

Recognizing "the integrity of society and the dignity of the individual is enhanced when every man is provided an opportunity to work and earn his own way in life," Governor James A. Rhodes of Ohio, on November 17, 1966, issued an executive order creating the Ohio Governor's Council on Vocational Rehabilitation.

Advances of a magnitude more consistent with Ohio's potential for rehabilitation services to the handicapped have long been a concern of state officials, professionals in the field of vocational rehabilitation and related disciplines, and Ohio's disabled and disadvantaged citizens.

On January 11, 1966 the Ohio Rehabilitation Association, prompted by 1965 federal amendments to the Vocational Rehabilitation Act granting up to $100,000 for each of two fiscal years for comprehensive statewide planning for vocational rehabilitation, unanimously declared its support of such a planning grant for Ohio in a serious effort to move Ohio's rehabilitation program substantially forward.

Thus the two-year Comprehensive Statewide Study of Vocational Rehabilitation was conducted July 11, 1966 - June 30, 1968 under the direction of the Governor's Council on Vocational Rehabilitation with the joint sponsorship of the Ohio Bureau of Vocational Rehabilitation and the Ohio Bureau of Services for the Blind.

A. Objectives and Orientation of The Ohio Two-Year Comprehensive Statewide Study of Vocational Rehabilitation

The Governor's Council first convened in the Cabinet Room of the State Capitol Building on December 2, 1966 and accepted the mandate to:

> determine the number, nature, and needs of the disabled in Ohio;
>
> evaluate present rehabilitation services and facilities in relation to these needs;
>
> and recommend immediate and long range actions required to provide for the needs of Ohio's handicapped by 1975 or earlier.

Over 700 Ohio citizens were organized by the Governor's Council into seven Regional Citizens' Committees, sixty-three Task Forces on study categories, six Statewide Ad Hoc Advisory Committees on study categories and a Statewide Advisory Committee on the Master Plan. Chapter V: Study Procedure provides a detailed account of the Study.

The planning effort in Ohio was based on a philosophy involving broad citizen participation, lay as well as professional, concentrated at the grass-roots level. It was felt that this approach was most likely to result in active local community support, as well as increased state level support, and would afford the best circumstances for subsequent implementation of a statewide array of rehabilitation programs to offer services to all the handicapped by 1975 or earlier. The effect of this philosophy and commitment to a decentralized local-regional emphasis on planning and implementation is tangibly illustrated by the necessity of publishing the Two-Year Study Final Report in eight volumes. This approach also provided working documents and a continued regional citizen-oriented organizational structure in all seven planning regions throughout the state.

The planning effort in Ohio was conducted in the context of recent federal legislation that has broadened the concepts of "physical and mental disability" and of "gainful employment" that are used by the Ohio Bureau of Vocational Rehabilitation. For the first time, "physical and mental disability" includes disorders characterized by deviant social behavior, socio-cultural deprivation, and impaired interpersonal functioning. "Gainful employment" is specifically defined to include farm or family work without cash remuneration, sheltered employment, and home employment. Critical issues and trends at the national and state levels related to the hard core unemployed, the inner city, delinquency, poverty, etc., were constant points of reference for the Study. The Final Report of The Ohio Governor's Council on Vocational Rehabilitation is therefore a direct and logical result of this broadly representative approach, both in citizen participation and philosophic commitment.

B. The Philosophy of Rehabilitation

Since its inception in 1920 with the enactment of The Federal Vocational Rehabilitation Law, vocational rehabilitation has steadily evolved until, at present, it encompasses a dynamic continuum of services,* which utilizes the skills of many professions and disciplines in a coordinated effort to rehabilitate the whole man, and make him a productive member of society.

---

* Refer to Figure 1.

Arising from concern for the disabled veteran of World War I and a subsequent transfer of interest to the civilian disabled citizen, the earliest efforts of vocational rehabilitation services were directed to those obvious things that could be done for those few who could benefit from a limited range of services. Help was provided in the choice of an occupation; job training in qualifying skills was offered almost immediately, along with assistance in finding a suitable job. Thus for many years the principal tools of rehabilitation service were guidance, training and placement. Recognition of medical, surgical, psychological and behavioral factors in disability were only slowly accepted. Even more slowly were services corresponding to these needs made available to the disabled. Yet through these gradual changes the basic concern for the individual's worth both in terms of himself and in terms of his community have provided the continuing vitality and relevance found today in the rehabilitation philosophy and process.

First focusing on children, the civilian rehabilitation movement was later extended to disabled adults; its impetus came largely from lay groups, who perceived the failure of existing institutions of the day either to appreciate the nature of the problems of the disabled or to seek their solutions. From this starting point, persons directly involved with rehabilitation services learned to recognize the capacities of the disabled as well as their needs.

In learning that established institutions and professions are relevant to the disabled person's needs, and successfully applied, only as they are relevant to the person as a whole, comprehensive services representing total needs of the individual were developed into an integrated pattern called "rehabilitation" or "the rehabilitation process." Rehabilitation techniques have a long history of evolvements and refinement. Increasingly difficult problems have involved increasingly diverse specialties in many areas of human skill and knowledge. Yet the philosophy and social movement underlying rehabilitation have not so much been changed as they have evolved into the present realization that the rehabilitation concept is one that can be applied to a broader array of social and behavioral problems besetting society today.

The history of rehabilitation has reflected a persistent conviction that fragmented or "compartmentalized" services and symptomatic relief applied to various human needs--physical versus mental versus social versus vocational potential--must give way to the philosophy of total enhancement, geared to a vocational objective. As a corollary, increasing attention is being given the referral maze that exists in most communities, in an effort to approximate the "one-stop,total service" ideal for those in need.

To compete in the mainstream of society, employment in particular, man must not merely be relieved of his disadvantage. Rather, his own unique potential and strength must be identified; and he must then be given adequate resources to allow him to become a self-reliant, productive contributor to society - economically, socially, vocationally and culturally.

In rehabilitation's recent history, amendments to the federal Vocational Rehabilitation Act in 1965 and 1968 have brought about significant advances in the federal-state rehabilitation programs and will continue to effect a broadening of the application of the rehabilitation philosophy and process to the needs of disabled and disadvantaged people. Substantially more clients will be characterized by severity of need and an etiological complexity comprising physical, mental, and social factors. Substantially more interagency joint funding and programming will result.

In context with the above-mentioned amendments, the reorganization of the U.S. Department of Health, Education and Welfare in August, 1967 created a department of Social and Rehabilitation Services, supplanting the welfare "dependency" concept by the infusion of the rehabilitation philosophy and emphasis as the objective of all programs under SRS jurisdiction.

The implications of these legislative and organizational changes are profound in their impact upon the disabled and disadvantaged and on the state rehabilitation programs. On the average, the vocational rehabilitation client will be more severely disabled, and in many more cases behavioral, social, and cultural factors will be dominant. Far more often, definitive vocational rehabilitation services will have to be preceded by personal and social adjustment and basic educational services. In fact, these services will often precede determination as to whether the individual can be rehabilitated at all. These trends are verified by new programs emerging from the 1968 amendments to the Vocational Rehabilitation Act (P.L. 90-391).

In the future, vocational evaluation and adjustment services will be available to the public offender, the narcotic addict, the alcoholic, the retarded, and the socio-culturally deprived with serious employment problems, without relating their eligibility for services in the traditional way to medically determinable physical or mental disabilities or to a prescribed intelligence quotient. The vocational rehabilitation agencies are, suddenly, free from many of the legal barriers which have prevented their acceptance of numerous handicapped persons who previously were not considered eligible for their services.

This new freedom, and the accompanying opportunities, present a number of problems to vocational rehabilitation agencies, one being the setting of priority criteria by which to program services. State rehabilitation agencies cannot, of course, attempt to serve all who now may be considered eligible for services under the more liberal definitions. In the future it will be increasingly necessary to plan for the provision of vocational rehabilitation services in the light of total community needs and planning, and the ability of vocational rehabilitation and other programs-i.e., employment services, public welfare, economic opportunity, parole authority, etc.- to share the burden and responsibility for the delivery of new and varied patterns of service. The state vocational rehabilitation agency will, however, be in much stronger position in the future to fulfill an important role in total community programs for the disadvantaged and disabled, including programs for those in poverty settings, programs for the institutionalized, etc., in addition to continuing its assistance to clientele of the state rehabilitation agency traditionally served in former years.

The aforementioned trend - exclusive of the 1968 amendments to the Rehabilitation Act and the reorganization with the Department of Health, Education and Welfare -- prompted a veteran in the field of rehabilitation to comment to his colleagues:

> "I am certain that each of you shares my feelings of excitment and anticipation at the unlimited opportunities for service that lie immediately ahead. I hope, too, that you share my concern that we be prepared to deal effectively with the new problems that now loom on the horizon.
>
> "The recent developments which appear to offer solutions to many of our service problems have, in turn, doubled and quadrupled the problems of the administrator. The new legislation, at this point, has not provided the solution to any of his

> problems, and has created a great many new ones. The problems are truly staggering in their immensity and we must be concerned with the manner in which they are met."[1]

Looking at the growth of the rehabilitation program nationally as an index of development, the number rehabilitated annually through the state-federal rehabilitation agencies increased from approximately 60,000 in 1955 to 137,000 in 1965 - and it appears the national goal of 200,000 rehabilitations will be achieved in 1968. This represents an increase nationally of 233% in 13 years. The Ohio Bureau of Vocational Rehabilitation by comparison has experienced a 384% increase in rehabilitations since 1955 with 5,616 in 1968 (Figure 2).

The Governor's Council Two-Year Study on Vocational Rehabilitation in Ohio indicates the need for a 5-6 fold increase in rehabilitations and services to the disabled by 1975 which would represent 24,000 rehabilitations annually (Figure 3).

Administrators of state rehabilitation agencies who have dealt with a 3-4 fold expansion rate over the past decade are now dealing with the new growth factors of 5-6 fold plus, as a result of the 1965 and 1968 amendments to the Rehabilitation Act. This remarkable growth, and an increasingly broader application of the rehabilitation philosophy and process to the physically, mentally and socially disabled and disadvantaged, will evidently continue, leaving little opportunity for rehabilitation management to consolidate on gains of prior years. The immediate future will test to the limit creative, capable and dedicated leadership in the state rehabilitation programs.

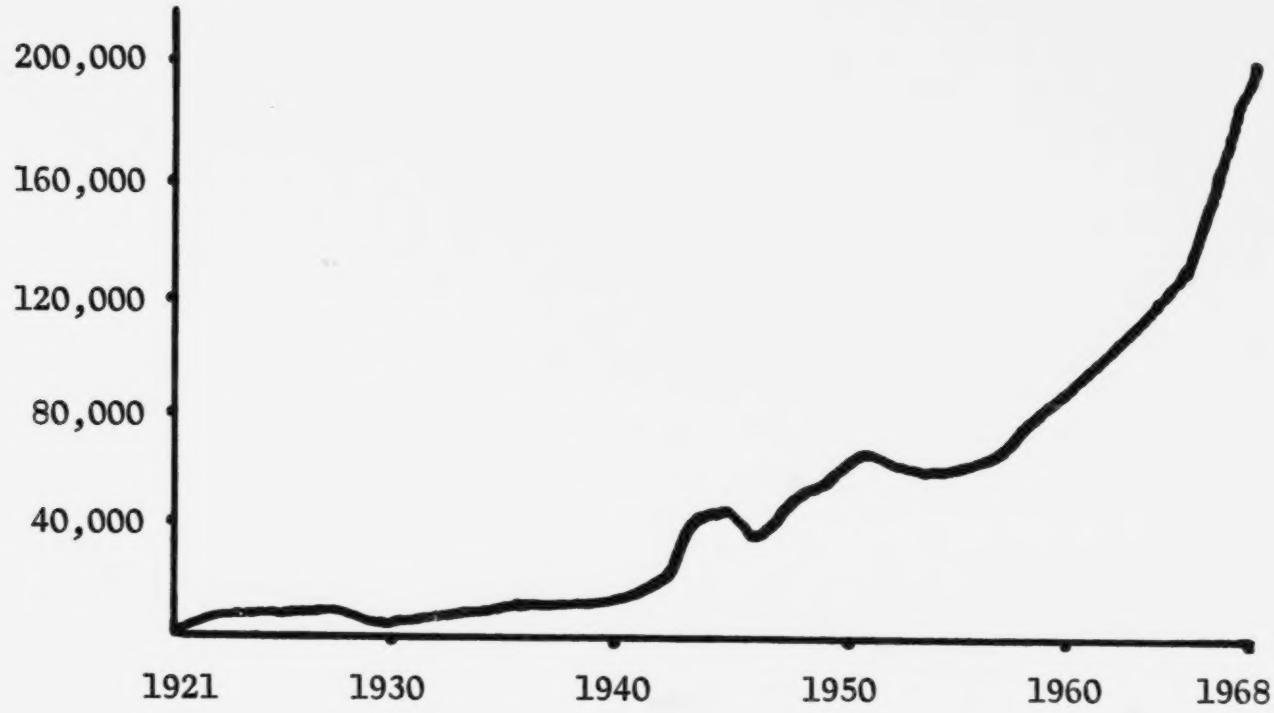
---

[1] Voyle C. Scurlock, "An Evolving Administrative Practice for Vocational Rehabilitation Programs" (delivered at the Annual Conference of the National Rehabilitation Association, Denver, Colorado, October 5, 1966). Mr. Scurlock is Coordinator, Vocational Rehabilitation Management Training, Extension Division, University of Oklahoma, Norman; and formerly Director of the Oklahoma Vocational Rehabilitation Division.

FIGURE 2

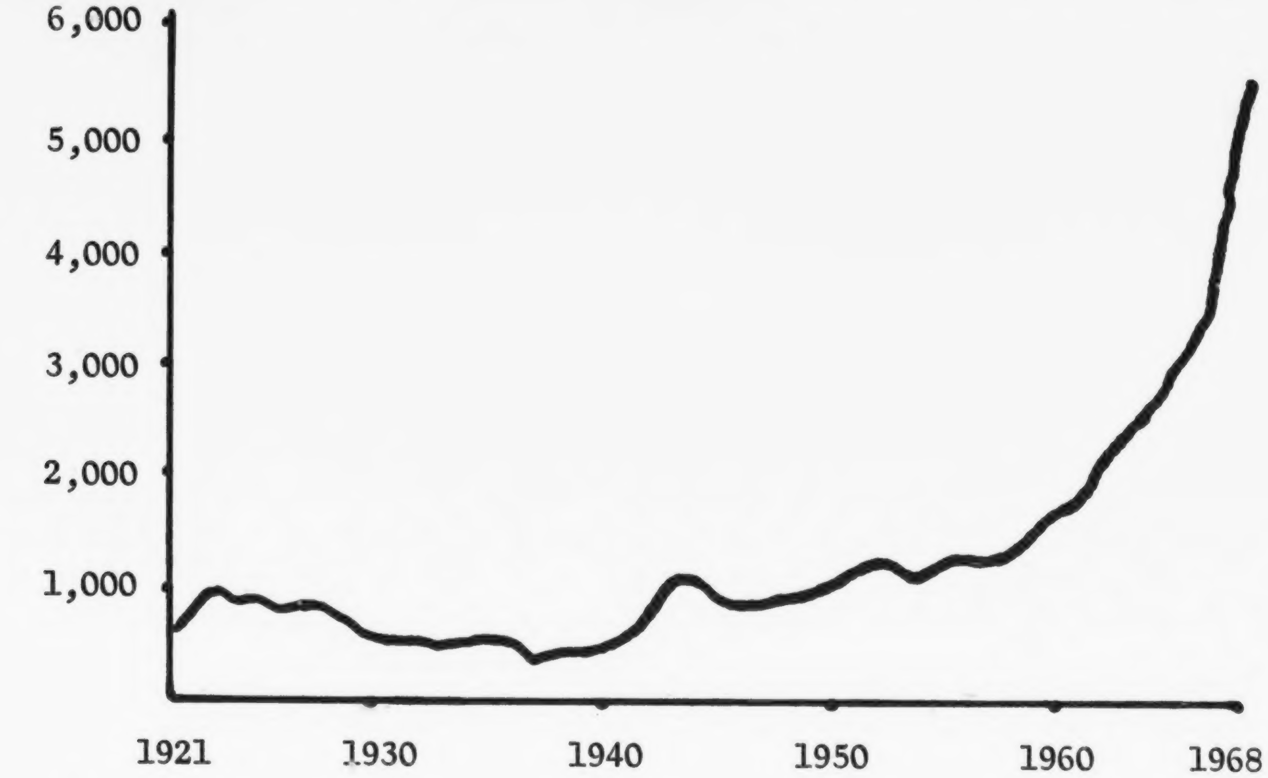
TOTAL NUMBER OF PERSONS REHABILITATED BY STATE VOCATIONAL REHABILITATION AGENCIES 1921-1968

NATIONALLY:



PERSONS REHABILITATED BY THE OHIO BUREAU OF VOCATIONAL REHABILITATION 1921-1968

IN OHIO:



C. Historical Development: The Nation

The public program for vocational rehabilitation, as it serves disabled and disadvantaged people today in all of the fifty-four states and territories, continues to expand as a flexible program and a creative partnership among federal, state, and local government. Rehabilitation legislation in recent years has been designed to stimulate investment in growth and provision of service in the private, voluntary services sectors, as well as in services provided cooperatively through various agencies of state government.

The historical growth of the state-federal rehabilitation programs, and their increasingly effective application to human problems of virtually every dimension in American society today, have paralleled an uninterrupted progression of significant federal and state legislative acts.

Rehabilitation services were first made available to American civilians with the enactment of the Smith-Fess Act of 1920. This limited range of services extended to civilians (including vocational guidance, training, occupational adjustment, prosthetics, and placement services) was a direct result of the humanitarian and economic values observed in the success of the Soldier Rehabilitation Act enacted immediately following World War I.

Four laws, representing major amendments to the Vocational Rehabilitation Act, appear to be responsible, basically, for stimulating the growth of vocational rehabilitation programs to their present proportions. Those laws are: Public Law 78-113 in 1943, Public Law 83-565 in 1954, Public Law 89-333 in 1965, and the very recent Public Law 90-391, 1968. Each of these laws served to broaden the legal and financial capability of state rehabilitation programs.

Along with other significant provisions of the rehabilitation laws, the Barden LaFollette Amendments of 1943 extended services to the mentally disabled; the 1965 Amendments to the federal Vocational Rehabilitation Act broadened the eligibility criteria for rehabilitation services to include behavioral disorders which render a person disabled from causes other than medically determinable physical or mental impairment. Financing for rehabilitation services has steadily improved as reflected in the federal-state matching ratios which have moved from 50:50 beginning in 1920, to 70:30 for some states (based on population and per capita income) between 1954 and 1966; and to the 75:25 matching ratio which became effective in 1967. Effective in fiscal 1970, the 1968 amendments to the Vocational Rehabilitation Act make joint federal-state funding possible on a federal 80%, state 20% basis for the state agency core program. The amendments also provide for a 90:10 ratio for a special program of diagnosis and evaluation to determine the vocational potential of a wide range of handicapped in reference to employment.

Perhaps the most dramatic prediction of the further rapid expansion of rehabilitation services is indicated by sections of the 1968 amendments enacted to expedite the delivery of those diagnostic and evaluative services necessary to determine the vocational potential of any youth or adult. This one section of the 1968 amendments should markedly increase state agency rehabilitation services both in the number and types of cases served by the agencies. Again, this will severely test agency management and staff development capabilities, as well as the viability of the whole state-federal rehabilitation program as it focuses on a new mix of disabled and disadvantaged people, many of whom are incarcerated in penal institutions, or in such prisons as anonymity, ghetto and Appalachia.

D. Historical Development: Ohio

Since 1921, the Bureau of Vocational Rehabilitation has been responsible for provision of vocational rehabilitation services to residents of Ohio who are vocationally handicapped by disability other than legal blindness. Under the federal-state rehabilitation program, the Bureau of Services for the Blind administers the rehabilitation program on behalf of the legally blind. Prior to July, 1953, these agencies operated under general provisions of the Revised Code of Ohio. In July, 1953, Amended House Bill 401 repealed certain sections of the Revised Code and enacted sections 3303.21 through 3303.35, giving a more specific legal framework within which Ohio's rehabilitation program would operate. The bill legally "created" a "bureau of vocational rehabilitation, delegating to it certain functions and authority," although the bureau had been operating for over three decades.

The State Plan, a basic document governing its program in accordance with the federal regulations, provides the actual framework within which the Bureau of Vocational Rehabilitation operates. The State Plan was amended July 1, 1966, to incorporate regulations resulting from the 1965 amendments to the federal Vocational Rehabilitation Act . It will now undergo additional revision in accordance with the 1968 amendments, which will further liberalize the State Plan.

In carrying out the Bureau's program, BVR vocational rehabilitation counselors help handicapped people develop vocational goals, and put them in touch with the community resources needed to achieve their goals: rehabilitation facilities and workshops, medical and/or psychological services, private agencies, educational institutions and job training programs. Counselors with the Bureau of Services for the Blind provide similar services to those handicapped with visual disability that meets the definition of legal blindness. Rehabilitation services often include providing the client occupational equipment and paying for his transportation and living costs during the rehabilitation period. In addition to job placement services, the state rehabilitation agencies provide follow-up services during adjustment to the job.

Impact of the 1965 Amendments

Program expansion can be measured in many ways. One measure is the increase in the number of clients served. The average percentage of increase in the number rehabilitated by the Bureau for the ten-year period beginning in 1965 was 8.8%. In the fiscal year 1965-66, the Bureau of Vocational Rehabilitation showed the largest percentage of increase since 1962--17.3%--by rehabilitating 3,172 clients. 3,698 handicapped Ohioans were rehabilitated in fiscal year 1966-67, an increase of 17% over the previous year. In fiscal year 1967-68 the number of rehabilitants and the percentage of increase were the highest recorded by the Ohio BVR: 5,616 rehabilitated for a 51.9% increase.

Program expansion was achieved during 1966 in the number of Bureau of Vocational Rehabilitation staff members and operational units providing rehabilitation services. During that fiscal year, in close cooperation with the Ohio Department of Mental Hygiene and Correction, the Bureau established vocational rehabilitation units in six state hospitals for the mentally ill, two for the mentally retarded, and one correctional institution. In addition, the Bureau initiated planning for similar units and programs for additional correctional institutions and special secondary schools.

By June 30, 1968, in addition to the seventeen district offices throughout the state, the Bureau was providing service through 13 state institutions for the mentally ill and mentally retarded, 2 state correctional institutions, and 5 schools offering occupational, vocational, or special education programs. One innovative unit, the Cleveland Inner

City Project, had been working intensively with the economically, culturally, and socially deprived.

REHABILITATION NEED AND PROGRAM POTENTIAL

Serving Ohio's disabled requires a six-fold increase in Ohio rehabilitation services by 1975.

In order to obtain and substantiate this fact, it was necessary first to acquire all previous health surveys and then to initiate further studies into the incidence and prevalence of disability among Ohioans. By this means, invaluable information for comprehensive planning was obtained and verified.

Various consulting agencies, such as Greenleigh Associates, Harbridge House, and the Regional Rehabilitation Research Institute at Madison, Wisconsin, were called in to assist in evaluating existing data and to perform new surveys to determine Ohio's rehabilitation needs. The main sources of data were:

The National Health Survey.

The Ohio Telephone Survey and Counselor Follow-Up, conducted by the Regional Rehabilitation Research Institute, University of Wisconsin.

Harbridge House, Inc., studies of Ohio's and other states' VR programs.

Greenleigh Associates, Inc., studies in Ohio, Michigan, and Pennsylvania.

The West Virginia Random Sample Survey, and other studies from states with population similar to Ohio or parts of Ohio.

A. Disabled and Disadvantaged Citizens in Ohio

The interpretation of existing data presented a myriad of difficulties. In general, each survey dealt with a particular sub-population and each used a somewhat different type of categorization of disabilities. In order to overcome these difficulties, each source of information was carefully analyzed to determine its value, and how it could be compared to, and augment, present information.

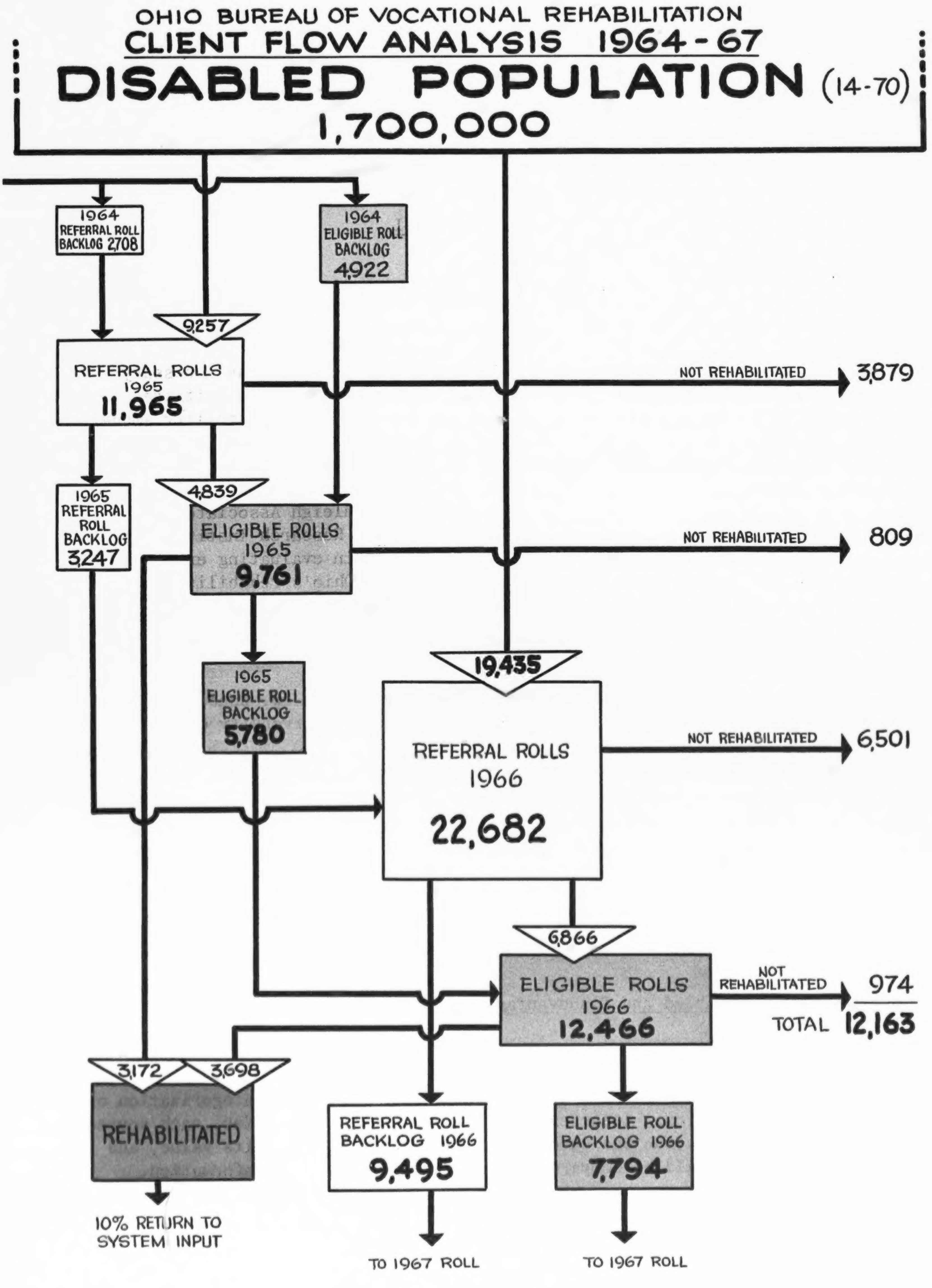

OHIO BUREAU OF VOCATIONAL REHABILITATION
CLIENT FLOW ANALYSIS 1964 - 67
DISABLED POPULATION (14-70)
1,700,000
1964 REFERRAL ROLL BACKLOG 2708
1964 ELIGIBLE ROLL BACKLOG 4,922
9,257
REFERRAL ROLLS 1965 11,965
NOT REHABILITATED
3,879
1965 REFERRAL ROLL BACKLOG 3,247
4,839
ELIGIBLE ROLLS 1965 9,761
NOT REHABILITATED
809
1965 ELIGIBLE ROLL BACKLOG 5,780
19,435
REFERRAL ROLLS 1966 22,682
NOT REHABILITATED
6,501
6,866
ELIGIBLE ROLLS 1966 12,466
NOT REHABILITATED
974
TOTAL 12,163
3,172
3,698
REHABILITATED
10% RETURN TO SYSTEM INPUT
REFERRAL ROLL BACKLOG 1966 9,495
ELIGIBLE ROLL BACKLOG 1966 7,794
TO 1967 ROLL
TO 1967 ROLL

FIGURE 3

Carefully defined disabled population types and disability categories were worked out. The main disabled population types were: those with a disability; those with activity limitations due to a disability; those disabled who are eligible and feasible for vocational rehabilitation services. The disability categorization used was the standard B.V.R. coding, condensed into 18 general categories.

Number of Disabled

The best estimation of the number of Ohioans with a disability was obtained from the Ohio Telephone Survey. 23.5%, nearly one quarter of those contacted in this survey, claimed at least one disability. This represents two and a half million Ohioans who would claim to have a disabling condition. Telephone Surveys obtained similar data in Illinois, Indiana, Michigan, Minnesota, and Wisconsin.

The interpolation of the National Health Survey to the total Ohio population of 10,700,000 showed that 12%, or about 1,284,000 people within Ohio's boundaries, had an activity limitation due to a physical or mental disability. This estimate is somewhat lower than estimates from the Ohio Telephone Survey (13.4%) and the West Virginia Random Sample (14.0%). All of these figures however, point to over 1¼ million Ohioans whose activities are markedly limited by a disability.

Eligible/Feasible Disabled

Many of those with an activity limitation are able to obtain employment without rehabilitation services; however, many are not. This group of more severely handicapped citizens, who could benefit substantially from rehabilitation services, is called the eligible/feasible "pool". It is a pool of people because, despite present rehabilitation efforts, the total number of those needing rehabilitation services is growing each year (Figure 3).

OHIO'S DISABLED and DISADVANTAGED POPULATION DEMAND for REHABILITATION SERVICES

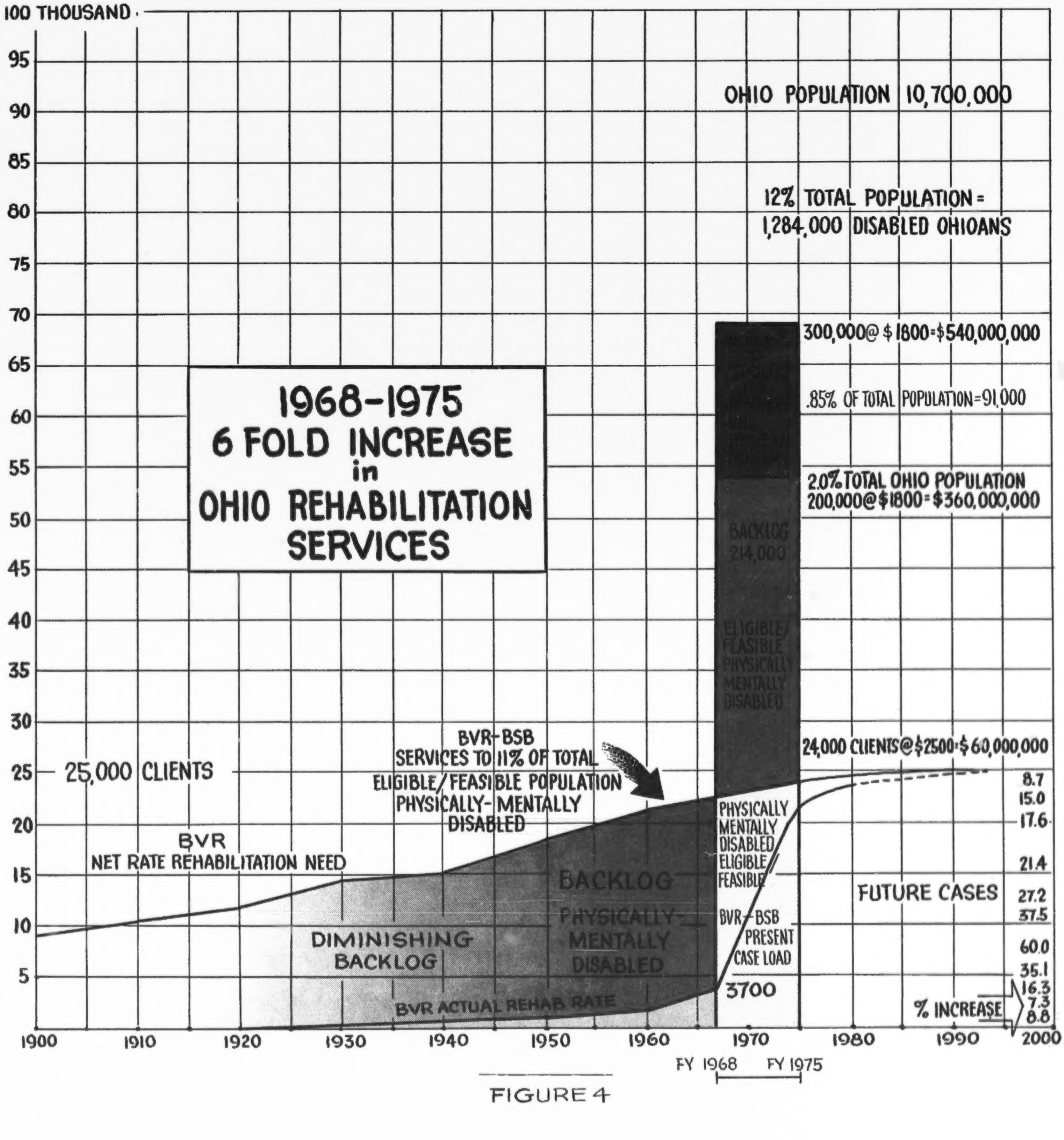


FIGURE 4

The Rehabilitation Services Adminstration (VRA)* estimates that 3.7 million Americans are in the eligible/feasible pool. If one considers Ohio to be statistically comparable to the entire nation, then Ohio's share of this figure is nearly 225,000. The RSA further estimates that the pool is growing nationally by 450,000 additional eligible/feasible per year, i.e., about 27,000 per year in Ohio. Later studies have shown that the RSA estimates are low, and their estimates do not include the socially disabled eligible/feasible. Estimates from Harbridge House and Greenleigh Associates point to at least 180,000 socially disabled eligible/feasible in Ohio. However, since one-half of these are recognized by other statistics, in that they also have a physical or mental disability, the socially disabled represent 90,000 additional eligible/feasible Ohioans not counted in most health surveys. Chapter IV: Supportive Data outlines statistical findings in further detail.

The RRRI Telephone Survey of Ohio showed that most previous estimations of Ohio's disabled population, interpolated from the National Health Survey, were somewhat low. Nearly one quarter of those sampled in the Telephone Survey listed at least one disability. Eligible/feasible estimates from this carefully performed survey showed the eligible/feasible population to be between 2% and 3% of the total population. This 2%-3% includes neither the approximately 90,000 socially disabled, eligible/feasible nor the institutionalized disabled. It does not represent residents who are not available by telephone; this latter group includes migrant workers and the more severely impoverished.

The total state institutionalized population is approximately 50,000. Of these, 30,900 are housed in Ohio state mental hospitals; 9,100 are confined in state correctional institutions; and 6,500 are found in non-state institutions. Detailed research into each category showed an additional 16,300 potential eligible/feasible.

The non-telephone households in Ohio account for 12% of the total state population, but the prevalence of disabilities is estimated to be about three times greater in homes with no telephone. Thus, a better approximation for this particular group would be 6% to 10% eligible/feasible, adding an additional 50,000 to 70,000 to the number of eligible/feasible disabled estimated from the Telephone Survey.

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* As part of the reorganization of the Department of Health, Education, and Welfare, the Vocational Rehabilitation Administration (VRA) was placed under the division of Social and Rehabilitation Services (SRS) and was renamed the Rehabilitation Services Administration (RSA). The editors of this report have followed references to the Rehabilitation Services Administration with the initials of its predecessor (VRA) to assist the reader. The name Vocational Rehabilitation Administration is retained, however, in specific references to documents issued by that agency prior to the reorganization.

In order to develop the whole picture of the eligible/feasible pool from 1900 to 1980, it was necessary to analyze (1) general population trends during this period; (2) birth and fatality rates for disabled during this period; (3) all existing records of incidence and prevalence of disability in Ohio. With this information it was possible to construct a graph, showing how the number of Ohioans needing vocational rehabilitation services has grown since 1900.

The graph (Figure 4) shows there are 200,000 eligible/feasible with physical or mental disabilities and an additional 100,000 socio-cultually disadvantaged Ohioans needing VR services today. It indicates further that this figure is growing each year. The projections from the graph coincide very closely with all estimates from recent random sample surveys mentioned above.

Thus, the research has shown that at least a six-fold increase in rehabilitation services is needed simply to keep the pool of disabled Ohioans from growing still larger. Again and again, independent studies and surveys substantiate the presence of at least 250,000 Ohio citizens who need, and who could benefit substantially from, vocational rehabilitation services.

B. State Rehabilitation Agency Profile and Potential

To be practically effective, the definition of rehabilitation for purposes of the Two-Year Comprehensive Statewide Study of Vocational Rehabilitation had to be set forth as an operational definition in its federal-state program legal and jurisdictional sense, as well as in its philosophical intent as developed at the outset of this report.

One constantly finds the rehabilitation concept misunderstood, erroneously stated or ill-conceived and misapplied at various levels of public life. Confusion abounds in legislative circles as well as among the general citizenry: the rehabilitation program is often equated with vocational or special education, or with other special categories of rehabilitation-type activity; and, in the extreme, the term brings to mind demolition of buildings and urban renewal. Terms such as "self-help" have been offered as substitutes for the term rehabilitation, but attempts to improve this situation have consistently failed.

Rehabilitation as practiced and funded within the federal-state programs is based on a philosophically derived viewpoint emphasizing the whole man, that totality of organic and functional elements which causes or enables function or malfunction, achievement or dropout, self-reliance or dependency. The statements that follow are included in this report with the hope of clarifying the use as it is applied to those services provided by federal-state rehabilitation programs. The statements further relate certain unique qualities that can, if understood and applied, greatly enhance other public and private agency programs having special jurisdictions for services to disabled and disadvantaged people.

1. Unique Qualities of Rehabilitation Programs

The Council of State Administrators of Vocational Rehabilitation, in its Statement of Mission and Goals, set forth six qualities that are unique to rehabilitation agencies in serving the disabled and disadvantaged. Briefly stated, these qualities are: comprehensiveness in services available, clients served, and geographical distribution of service; and flexibility in administration, funding, and provisions for staff education and training.

The vocational rehabilitation agencies are responsible for providing vocational rehabilitation services to all disabled youth and adults with employment problems.

The vocational rehabilitation agencies have authority to provide substantially all of the services that are needed to evaluate the rehabilitation potential of the individual and prepare him for employment.

The services of a state vocational rehabilitation agency are available on equal terms to handicapped people in all subdivisions of the state.

Laws and regulations governing the administration of rehabilitation programs in the state are flexible, enabling the state agency to work with related agencies in almost any way that will expedite the rehabilitation of handicapped people.

The flexibility of funding of state vocational agency programs makes it possible for state vocational rehabilitation agencies to be experimental and innovative in their approach in the provision of rehabilitation services.

The availability of funds for education and training of staff, both institutional and in-service, has enabled the state vocational rehabilitation agencies to make rapid strides in expanding their staffs and increasing their effectiveness.[1]

These qualities, as quoted, apply in varying degrees to the state rehabilitation program in Ohio. Potentially, Ohio's rehabilitation agencies can make available to clients the benefits resulting from all these qualities.

2. Supplementing Other Human Service Programs

In some human service programs, the purchase of comprehensive services (i.e., medical, psycho-social, pre-vocational for those who have potential for vocational adjustment) is minimal or impossible, due to a more limited jurisdiction, and funding, for only special aspects of total rehabilitation. In some instances, custodial or subsistence operations dominate the program. The state rehabilitation agency (Figure 9, Chapter II) is in a position legally and financially to complement and supplement existing human service programs so that comprehensive services may be provided.

An unusual flexibility in its laws and regulations permits the state rehabilitation agency to work cooperatively with both public and private agencies in the delivery of services to all ages and all categories of the disabled and disadvantaged.

Further enhancing this programming is a flexible funding capability that may be implemented at the state government level or in any of its political subdivisions. A variety of funding sources makes it possible to initiate cooperative agreements with the private agency sector as well as public agencies. It is characteristic of some state rehabilitation programs, such as in Ohio, to purchase most client services from various resources in the local communities.

Although this flexibility lends itself to complexity in management and control, it has also been basically instrumental in effecting the remarkably rapid expansion of the federal-state rehabilitation program throughout the nation. Without this broad flexibility it would be impossible to apply the rehabilitation philosophy and process to such a variety of handicapping conditions in context with multiple medical-psycho-social disciplines and within a complex network of public/private agency programs.

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[1] The State-Federal Vocational Rehabilitation Program Looks to the Future: A Statement of Mission and Goals (Washington: Council of State Administrators of Vocational Rehabilitation, 1967), pp. 6-7.

The State rehabilitation agency seems ideally suited to complement any state agency program concerned with human services, by offering expertise and funding for services required to evaluate the vocational potential of individuals in reference to their medical, psycho-social and training needs. As documented in Chapter IV: Supportive Data, there are substantial percentages of the individuals served under other jurisdictions in state government who are eligible and feasible for these rehabilitation services, which are designed to move them from dependency and unproductiveness to employment and independence.

Ohio has a long history of heavy investment in the private sector service programs, both in terms of facility development and in the purchasing of rehabilitation services. Other states have opted to develop and promote direct services by state operated facilities. Obviously, the latter mode of application of federal-state funds lends itself more readily to state agency control of types and quantities of rehabilitation services provided.

3. Statistical Evaluation of Program

Due to its heavy investment in the private agency sector, it is estimated that the Ohio Bureau of Vocational Rehabilitation reports statistically on approximately 20% of those rehabilitated throughout the state annually. It can be further estimated (Greenleigh Survey) that through firm contractual agreements with both public and private agencies, wherein the Ohio Bureau of Vocational Rehabilitation would make sizeable investments of federal-state funds for rehabilitation, given adequate reporting techniques, the Ohio state rehabilitation agency's actual performance, in terms of successful rehabilitations directly attributable to the state agency program, would be sizeably increased.

This policy of developing the Ohio rehabilitation program by stimulating private agency services is commendable in many respects. However, it poses serious problems in terms of accurately and effectively presenting, to the leaders in state government, the strengths and economic effectiveness of the agency. Ohio in 1967 ranked 3rd of the 54 states and territories in the number of successful rehabilitations per 100,000 population attributed directly to its program.[1]

The Ohio Bureau of Vocational Rehabilitation has made notable progress, especially during the years 1966-1968, in investing much more substantially in state-operated rehabilitation programs. Ohio, reportedly a leader nationally, as of June 30, 1968, had eighteen special rehabilitation units in Ohio's mental hospitals, institutions for the mentally retarded, correctional institutions (including those for the youthful offender), vocational schools, occupational schools, and special education.

4. Program Potential and Economic Viability

These units, operating to select, evaluate, counsel, prepare, and place disabled and disadvantaged into employment and independent living, will in the near future undoubtedly add substantially to the Ohio Bureau's ability to report on program effectiveness.

Ohio should emerge in the near future, well documented as a leader in the field of rehabilitation and human services programs given the following conditions:

the experience of a few years in these highly innovative special units dealing with the public offender, the emotionally ill, the mentally retarded, the culturally and economically deprived;

continued effective manpower development, corrected retention practices and new manpower utilization techniques;

improved reporting techniques on investment in the private sector;

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[1] State Vocational Rehabilitation Agency Program Data: Fiscal Year 1967; Rehabilitation Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare (Washington: U.S. Government Printing Office, 1968), p. 15.

demonstrated management, control, and overall program effectiveness and the fiscal benefits of the rehabilitation program approach to human services;

full utilization of the federal-state financing which would allow expansion in services represented in a $60 million state rehabilitation program within the next six years, as compared with the present $12 million budget of the Ohio BVR-BSB programs.

By philosophic and legislative involvement, the federal-state rehabilitation services emphasis is both timely and critical to the fulfillment of current demands of the economist as well as of the administrator of human services programs: to deliver comprehensive services to the whole man with full cognizance of his vocational potential in a manner compatable with sound economic principles.

In addition to the example of costs benefits based on the increased earnings of rehabilitated clients (Figure 1), the following analysis indicates the economic returns to one state, over a one-year period, on total investment in that state's rehabilitation program. Those persons rehabilitated returned to or saved for the state, in one year, more than $1.67 for each dollar the state invested in rehabilitation.

TABLE I

REHABILITATION: RETURN ON INVESTMENT

Source of Returns to the State	Returns In One Year
Increase in state sales tax paid by rehabilitated persons	$ 37,850
Increase in state income tax paid by rehabilitated persons	65,998
Savings in state funds on public assistance	152,091
Savings in state funds for support of persons in public institutions	1,607,661
	$1,863,600
Total state expenditures on vocational rehabilitation in one year	$1,113,113

The data used in Table I are actual figures for a state for a recent year.[1]

DIMENSIONS OF THE FUTURE

Major Variables Affecting Rehabilitation Programs in Ohio

As heretofore described, the profile or essential nature of the Ohio Bureau of Vocational Rehabilitation is affected, molded, and subjected to a state of flux and change by virtue of certain readily identifiable factors. Two major variables are philosophy and legislation. Several additional factors cause the state agency rehabilitation program to be as it is, or change from time to time, in its priorities, scope and effectiveness of operations. Figure 7 depicts some of the critical interdependent parts of the total Rehabilitation System.

The will of the people and the views of federal and state legislation must be taken into serious account.

Critical local and national social problems as they change in intensity and kind must be major considerations (i.e., juvenile delinquency, crime, urban violence, poverty, disease, war, etc.).

The agency mandate and legal jurisdiction must be considered in relation to other functions of governmental agencies dealing with human services, to determine its appropriate and most efficient function.

Rehabilitation philosophy and process.

Public understanding of the rehabilitation philosophy and process.

State rehabilitation agency image, access and visibility in reference to federal and state government.

Federal and state rehabilitation legislation.

Federal financial allotment.

State matching funds for rehabilitation.

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[1] State Vocational Rehabilitation Agencies Regions I and II, Statistics in Vocational Rehabilitation: Proceedings of the Bi-Regional Statistical Seminar for Administrative Personnel (South Orange, New Jersey: Seton Hall University, October 23-25, 1967), p.21.

Size and characteristics of state population (prevalence of disabilities, economic conditions, etc.).

State rehabilitation agency plan, organization and leadership (application of philosophy and law).

State agency program balance of investment through: public and private agencies, vocational and medical aspects, etc.

Staff recruitment and training capability.

System management and control.

Actual effective delivery of service to disabled and disadvantaged.

Substantiation of values (human and economic) of the rehabilitation philosophy and process to the public, the legislature and the administration.

Criteria for Establishing State Rehabilitation Agency Program Priorities

The above major variables that vitally affect Ohio rehabilitation services as they relate to the Federal-State program must certainly be considered as state rehabilitation agency mission, goals and priorities are generated, changed, or consolidated and reaffirmed. However, interrelated with these major factors are other criteria for establishing program priorities.

Services must be made available to all disabled and disadvantaged within legal limits.

Available financial and facility resources must be equitably distributed and spread to reach as many of the urban and rural disabled and disadvantaged as administratively feasible.

A. State Agency Adjustments for the Future

Ohio's rehabilitation agency performance has been studied in the light of the above variables with the following major problem areas included among the general conclusions substantiated by the Study Findings.*

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* Cf. Chapter II: Master Plan - Major Recommendations and Chapter III: Specific Recommendations By Study Category.

COMPARISON: FEDERAL ALLOTMENTS WITH ACTUAL OHIO BVR-BSB PROGRAM FUNDING

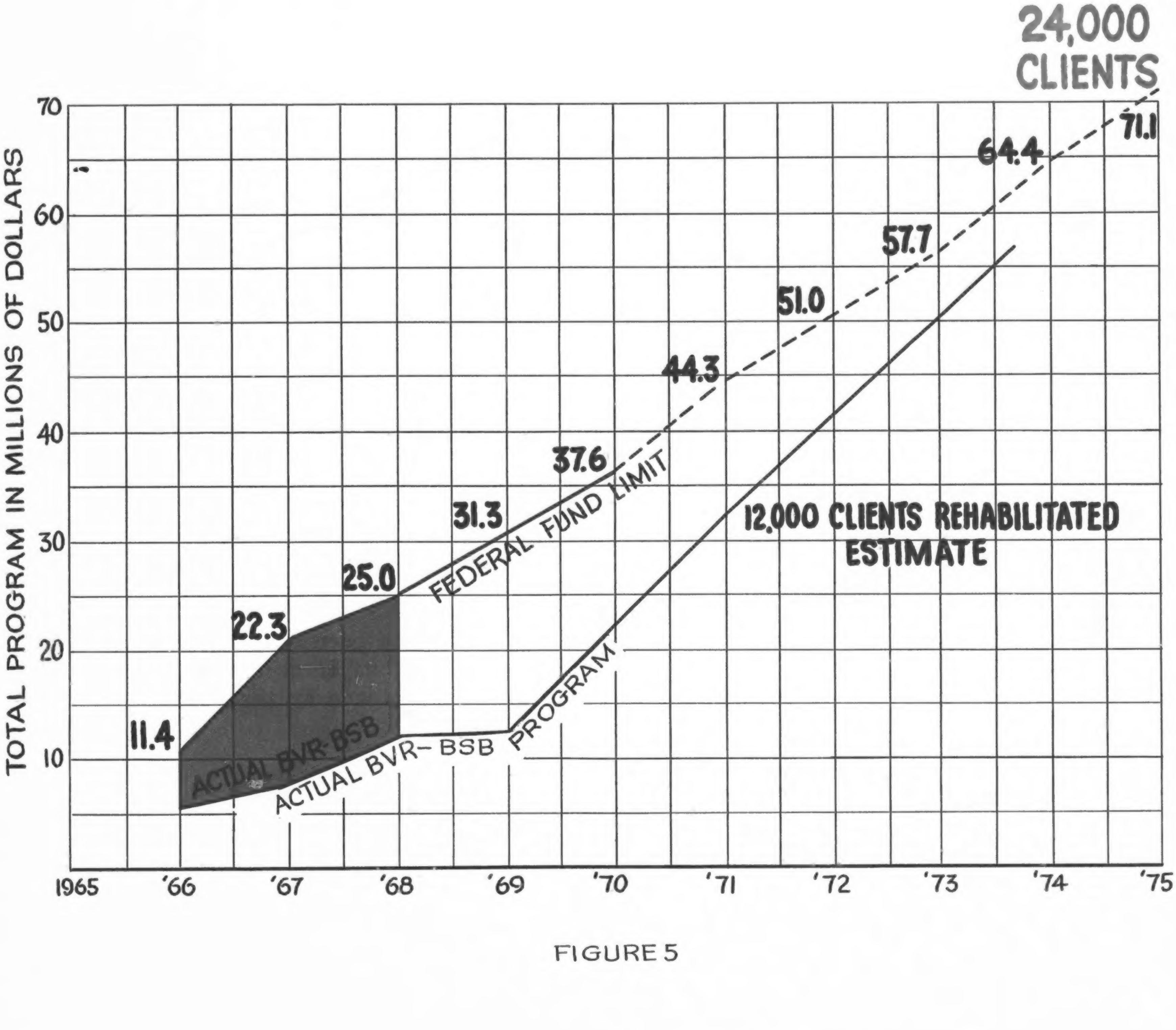


FIGURE 5

1. Public Understanding of the Rehabilitation Philosophy and Process

The essential nature and economics of rehabilitation programs must be clearly demonstrated to state government and the general public in Ohio. Also, and perhaps more basically, the relevance of the rehabilitation program to current critical priorities in Ohio must be unmistakably apparent. Quite naturally state funds will not be available for those programs of the state government not clearly delineated to and understood by state legislators and the administration. In addition, legislators and other leaders in state government are unlikely to support programs vaguely understood by the general public, or programs not directly relevant to, or considered to be of high priority by, Ohio citizens.

2. State Rehabilitation Agency Image, Access and Visibility in Reference to Federal and State Government

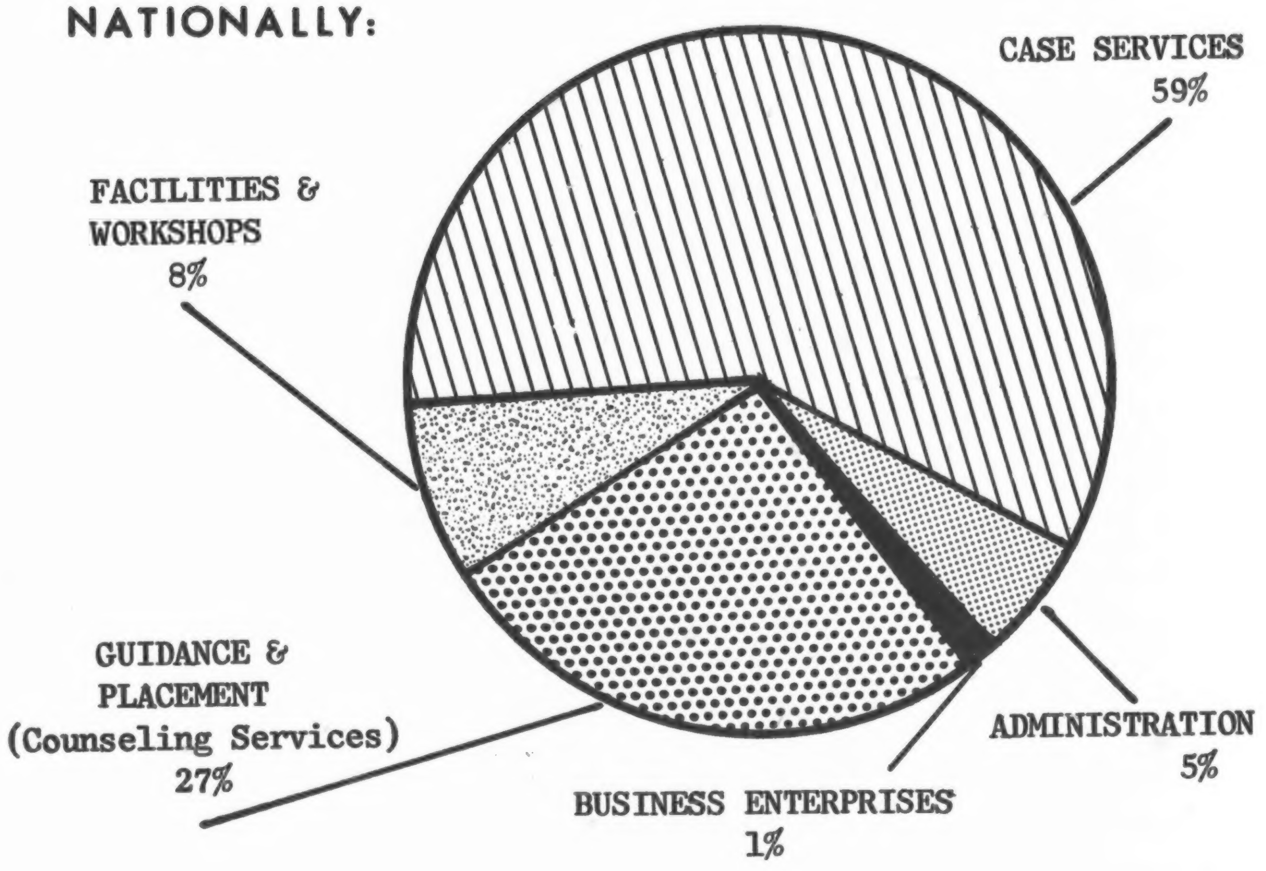
The 384% Ohio BVR agency growth over the past thirteen years; the projected six-fold increase of services through 1975; a state government program characterized further by complex legislation and financing, and multidisciplinary operations; these factors have clearly recommended the need for vastly improved agency program visibility and access in state government. Very substantial improvement is essential in this respect to effect adequate communication of the meaning and significance of rehabilitation to the people of Ohio and to officials in state government. This program offers dramatic human and economic possibilities for priority groups of disabled and disadvantaged, i.e., the hard core unemployed, the socio-culturally disadvantaged of the ghettos and Appalachia, the institutionalized who are readily accessible to rehabilitation programs and who, without them, remain hopelessly confined and subsidized by the state. Additional information on the position of the state rehabilitation agency in state government is given in Chapter II, Recommendation One.

3. State Matching Funds

Federal financial allotments for Ohio are directly in line with the projected needs of those of Ohio's disabled, disadvantaged people considered to be the Ohio BVR's responsibility (See Figure 5).

HOW THE REHABILITATION DOLLAR WAS SPENT IN 1967

NATIONALLY:



IN OHIO:

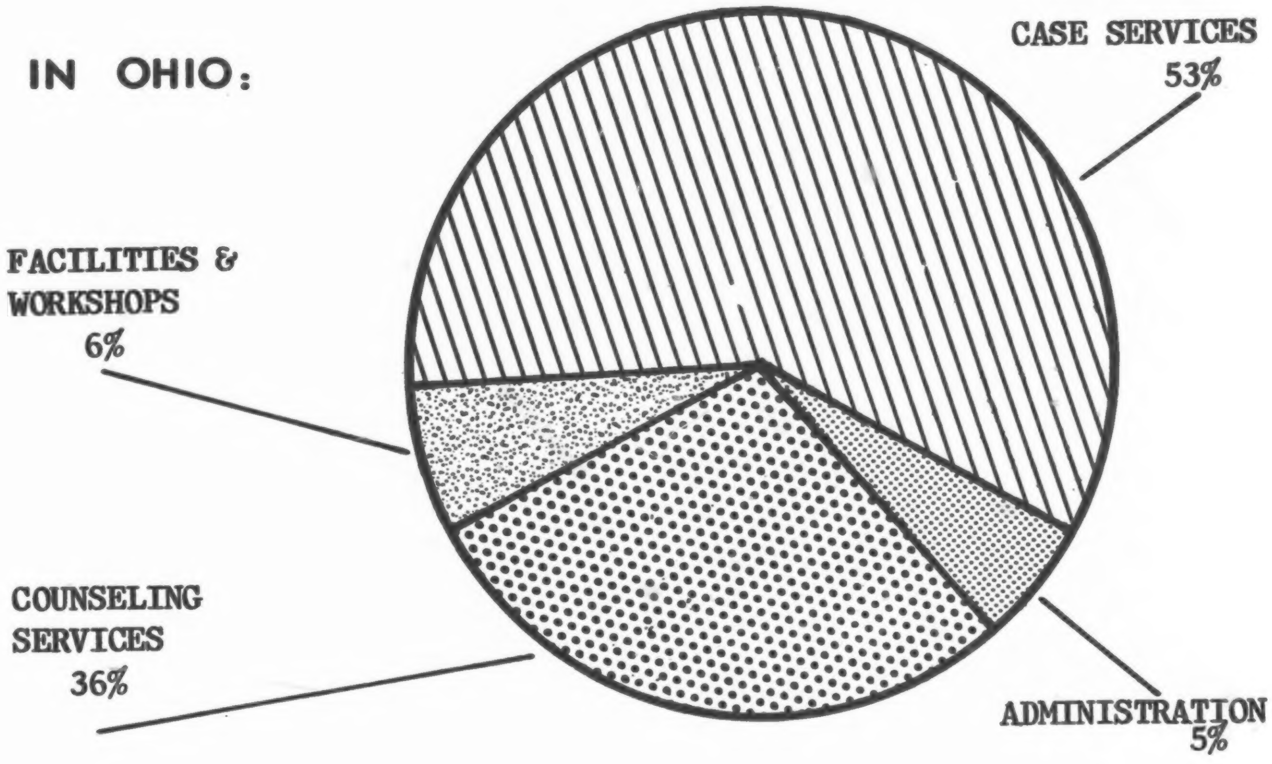


FIGURE 6

However, state funding at a level consistent with Ohio's per capita capability, and state rehabilitation agency performance comparable to the performance in states of similar size and composition, have been seriously lacking. Weaknesses in the two elements (#1 and #2) set forth above have, in general, been isolated as basic causes for the low level of funding for rehabilitation services in Ohio. For some reason or causes, if not the above mentioned two, Ohio has consistently compared very unfavorably with other states in its rehabilitation rate (ranking from 51-54 out of 54 states and territories in recent years). As a corollary to performance rating, Ohio ranked 51st out of 54 (1967) in state per-capita expenditures for vocational rehabilitation services: .79 compared with $2.17 for Pennsylvania, $3.41 for West Virginia, $4.07 for Arkansas, which rank 9th, 4th and 1st respectively in the 54 states and territories. See Figure 16, Chapter IV.

In recent years Ohio has been unable to utilize more than 30-40% (BVR-BSB combined) of its federal allotment. As a result, this nationally accepted and increasingly effective philosophy and process is seriously under-utilized in this state. The philosophy and process have demonstrated throughout the country an efficiency and cost effectiveness unequalled by any other federal-state program dealing with severe people/ employment problems. Because of the rehabilitation orientation, welfare rolls, institutional populations, public offenders, the inner city disadvantaged, etc., are becoming prime target populations for the state rehabilitation agency programs. Ohio's commitment to self-help, vocational goals and employment make it difficult to understand its lack of utilization of this effective program.

4. State Agency Plan, Organization and Leadership

The acute pressure exerted on state rehabilitation agencies throughout the United States and its territories as a result of a succession of liberalized amendments to the Federal Vocational Rehabilitation Act has been amplified earlier in the chapter with reference to the historical development of rehabilitation. As one might expect, there have been rather wide variations among states in their ability to adjust State Plans to the new legislation and set up guidelines and objectives for field units and offices that would fully reflect the progress in federal legislation and funding.

This Report will verify outstanding movement and progress by the Ohio Bureau of Vocational Rehabilitation in innovative programming and development, as well as forward-looking staff development programs. The Harbridge House, Inc. agency effectiveness study indicates, however, a serious lack in overall planning of agency objectives, monitoring and control mechanisms, etc., that would relate new program development and nuances in the State Plan to the traditional service patterns and field management of the past, and regulate and predict growth. (Refer to Chapter V: Supportive Data).

The critical demand for overall management and control of the expansion of the Ohio Bureau of Vocational Rehabilitation was reflected in fiscal year 1968 by the inability of the Bureau to accurately apply its financial resources to its expanding program, and consequent requirement of additional emergency appropriations from the State Controlling Board. Also, perhaps more seriously affecting the projected program growth in the months and years in the immediate future, was the extensiveness of resignations from the BVR staff during fiscal 1968.

The goal of 24,000 rehabilitations annually by 1975, and the consequent goal of 8,000 rehabilitations in 1969, are not unreasonable objectives for the Bureau of Vocational Rehabilitation, particularly in the light of the very favorable staff complement of 1967 and the 51.9% increase in rehabilitations in 1968. However, in view of the loss of experienced staff, certain remedial and compensating measures will have to be applied by the Bureau if these goals are to be achieved in 1969 and 1975.*

The Governor's Council Two-Year Comprehensive Study of Vocational Rehabilitation, from the outset, placed foremost as an objective: to study rehabilitation strengths in Ohio but also to understand more clearly the causes of low performance in relation to the rich and diverse resources available for rehabilitation services in Ohio. The delineation of problems and their causes are solely an attempt to give Ohio citizens the quantity and quality of services needed and enable Ohio thereby to be rated in rehabilitation as a national leader—as Ohio ranks in other activity.

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* Cf. "Manpower", Chapter III: Specific Recommendations by Study Category.

GENERAL FEATURES OF THE STATE VOCATIONAL REHABILITATION AGENCY MODEL

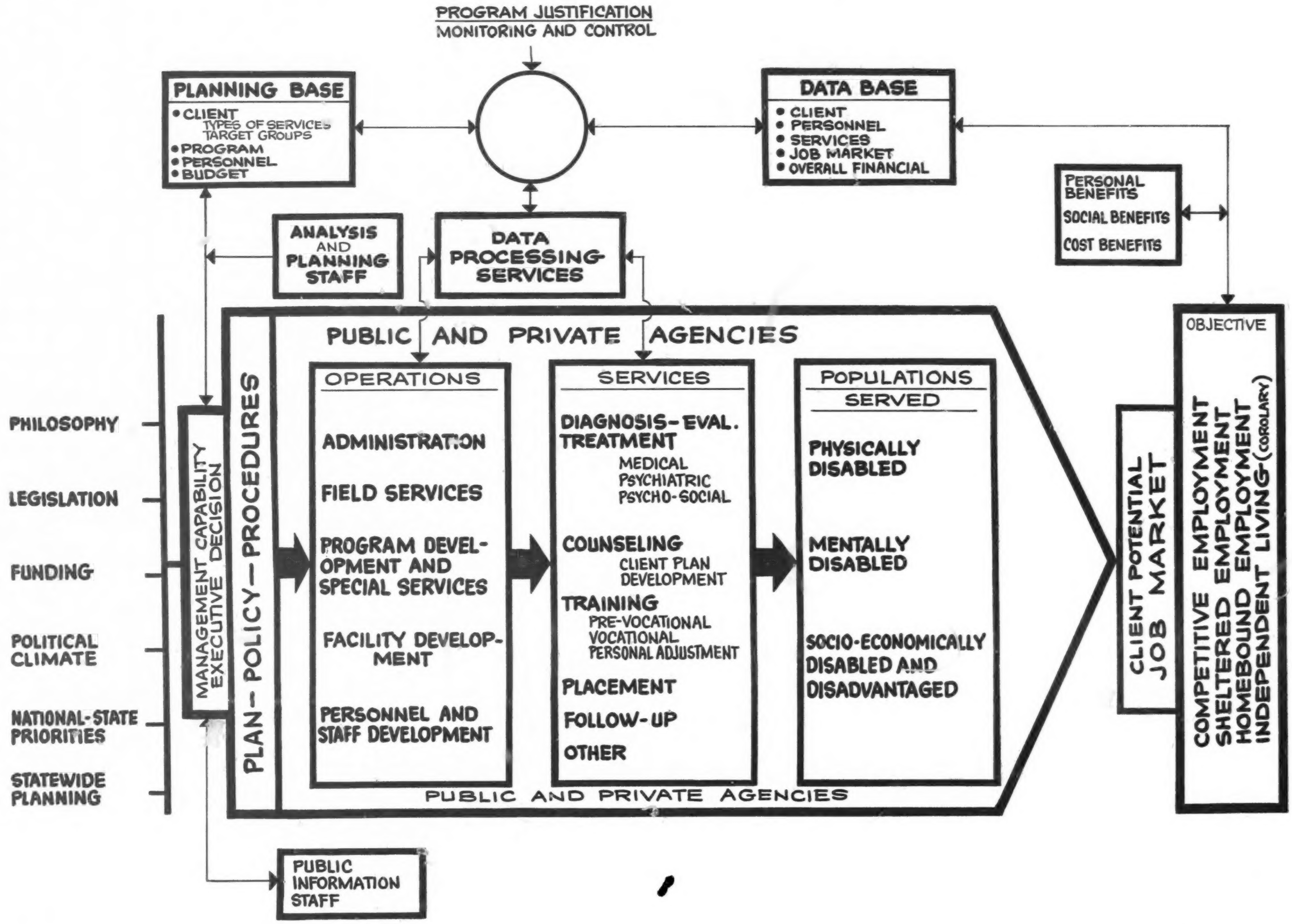

PROGRAM JUSTIFICATION
MONITORING AND CONTROL
PLANNING BASE
• CLIENT
TYPES OF SERVICES
TARGET GROUPS
• PROGRAM
• PERSONNEL
• BUDGET
DATA BASE
• CLIENT
• PERSONNEL
• SERVICES
• JOB MARKET
• OVERALL FINANCIAL
PERSONAL BENEFITS
SOCIAL BENEFITS
COST BENEFITS
ANALYSIS AND PLANNING STAFF
DATA PROCESSING SERVICES
PUBLIC AND PRIVATE AGENCIES
OPERATIONS
ADMINISTRATION
FIELD SERVICES
PROGRAM DEVELOPMENT AND SPECIAL SERVICES
FACILITY DEVELOPMENT
PERSONNEL AND STAFF DEVELOPMENT
SERVICES
DIAGNOSIS-EVAL. TREATMENT
MEDICAL
PSYCHIATRIC
PSYCHO-SOCIAL
COUNSELING
CLIENT PLAN DEVELOPMENT
TRAINING
PRE-VOCATIONAL
VOCATIONAL
PERSONAL ADJUSTMENT
PLACEMENT
FOLLOW-UP
OTHER
POPULATIONS SERVED
PHYSICALLY DISABLED
MENTALLY DISABLED
SOCIO-ECONOMICALLY DISABLED AND DISADVANTAGED
PUBLIC AND PRIVATE AGENCIES
PHILOSOPHY
LEGISLATION
FUNDING
POLITICAL CLIMATE
NATIONAL-STATE PRIORITIES
STATEWIDE PLANNING
MANAGEMENT CAPABILITY
EXECUTIVE DECISION
PLAN — POLICY — PROCEDURES
CLIENT POTENTIAL
JOB MARKET
OBJECTIVE
COMPETITIVE EMPLOYMENT
SHELTERED EMPLOYMENT
HOMEBOUND EMPLOYMENT
INDEPENDENT LIVING-(COROLARY)
PUBLIC INFORMATION STAFF

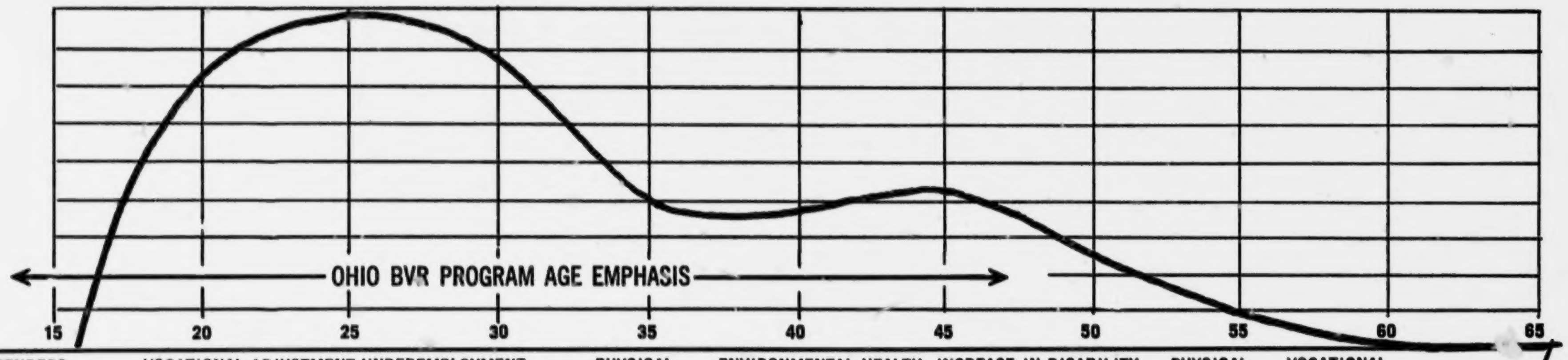
FIGURE 7

—HUMAN SERVICES AND AGENCY COMPLEX—

(SHOWN ON AGE CONTINUUM)

CONTEXT WITHIN WHICH CLIENT CENTERED REHABILITATION SERVICES MUST BE PLANNED AND COORDINATED

SIMPLIFIED BVR SERVICES PROFILE	**AGE JURISDICTION:** ALL AGES **PROBLEM COVERAGE:** PHYSICALLY, MENTALLY, SOCIO-ECONOMICALLY DISABLED AND DISADVANTAGED **CLIENT EMPHASIS:** WORKING AGE GROUP — FEASIBLE FOR COMPETITIVE EMPLOYMENT — SHELTERED OR HOMEBOUND EMPLOYMENT **SERVICES:** COMPREHENSIVE — AS PLANNED FOR INDIVIDUAL CLIENT: — PURCHASING OF SERVICES, ADVOCACY AND REFERRAL WITH PUBLIC AND PRIVATE AGENCIES **SETTINGS:** LEGAL CAPABILITY TO PLAN REHABILITATION SERVICES WITH MOST REHABILITATION SERVICES RELATED AGENCIES



AGE CONTINUUM	5 — 10 — 15 — 20 — 25 — 30 — 35 — 40 — 45 — 50 — 55 — 60 — 65
PROBLEM	CONGENITAL DEFECTS PHYSICAL EMOTIONAL RETARDATION SOCIO-ECONOMIC JUVENILE OFFENDERS DELINQUENTS H.S. DROPOUTS DEPENDENCY VOCATIONAL ADJUSTMENT UNDEREMPLOYMENT HIGHWAY ACCIDENTS INDUSTRIAL ACCIDENTS DRAFT REJECTEES DRUG ADDICTION SOCIO-ECONOMICALLY DISADVANTAGED PHYSICAL MENTAL SOCIAL ENVIRONMENTAL HEALTH FACTORS ALCOHOLISM DEPENDENCY INCREASE IN DISABILITY SPECIFIC FUNCTIONS WITH AGE PHYSICAL MENTAL SOCIAL DEPENDENCY VOCATIONAL ADJUSTMENT DISENGAGEMENT FROM WORK FORCE
FUNCTIONAL GOALS	PREVENTION EARLY DETECTION DEVELOPMENT MAXIMUM UTILIZATION OF INDIVIDUAL POTENTIAL AND WORK FORCE RESOURCES SELF-HELP SELF-RELIANCE VOCATIONAL AND AVOCATIONAL ADAPTATION
SERVICES	MEDICAL REMEDIAL-RESTORATIVE PSYCHIATRIC-PSYCHO-SOCIAL ECONOMIC NORMAL EDUCATION SPECIAL EDUCATION COUNSELING PERSONAL ADJUSTMENT TRAINING VOCATIONAL/OCCUPATIONAL TRAINING HIGHER EDUCATION PRE-VOCATIONAL — VOCATIONAL EVALUATION — TRAINING PLACEMENT FOLLOW UP OUTREACH— ADVOCACY — REFERRAL CUSTODIAL SERVICES SHELTERED EMPLOYMENT HOMEBOUND EMPLOYMENT MEDICAL PSYCHIATRIC PSYCHO-SOCIAL RE-EVALUATION — RETRAINING — PLACEMENT 2ND CAREERS — SHELTERED EMPLOYMENT ACTIVITY CENTER ADJUSTMENT COUNSELING LONG TERM CARE
SETTINGS	HOSPITALS CLINICS RESEARCH CENTERS PUBLIC SCHOOLS VOCATIONAL/OCCUPATIONAL SCHOOLS COMMUNITY CENTERS — HALFWAY HOUSES — PRE-RELEASE CENTERS — RESIDENTIAL HOMES HOME SERVICES BUSINESS AND INDUSTRY RETIREMENT CENTERS HOMES FOR AGING INSTITUTIONS: EMOTIONALLY ILL — RETARDED — YOUTH DIAGNOSTIC AND CORRECTIONAL — ADULT CORRECTIONAL CITY, COUNTY JAILS LONG TERM CARE CUSTODIAL ACTIVITY CENTERS OTHER FACILITIES: HOSPITALS — CLINICS — COMP. REHAB. CENTERS — COMP. MENTAL HEALTH CENTERS — SINGLE DISABILITY — SHELTERED WORKSHOPS — NEIGHBORHOOD CENTERS — MOBILE UNITS
AGE CONTINUUM	5 — 10 — 15 — 20 — 25 — 30 — 35 — 40 — 45 — 50 — 53 — 60 — 65
Public and Private Agencies with Rehabilitation Emphasis and/or High Rehabilitation Potential	CHILDHOOD — DEVELOPMENTAL — ADOLESCENCE — MATURING — YOUTH — ADULT — ADULT — AGING — AGING OSCCA — OYC — OBES — ICO — OBWC OARC — ODE — OEA — ODPW — DMHC-AA — OHA UCPO — OSHA — OSMA — OSDA — OSCCA — OHA — CCUA — ACS — ODUA — OMHA — OMHF — ODMHC — ODPW — OCCHW — LHWF — GCHH — OCC — OPHA — ORA — OWC

FIGURE 8

AGENCIES AND ORGANIZATIONS RELATED TO REHABILITATION SERVICES PLANNING IN OHIO
(Apply to Figure 8)

PUBLIC AGENCIES (Sample Listing)

ODE	Department of Education
	Special Education, Vocational Education, Public School Systems, - Inner City Schools
ODMHC	Department of Mental Hygiene and Correction
	Mental Illness, Mental Retardation, Corrections, Parole Authority
OYC	Youth Commission
ODPW	Department of Public Welfare
	Regional Public Welfare Offices
	Bureau of Services for the Blind
	Bureau of Crippled Childrens Services
	Public Assistance, Title V, Title IX, etc.
OBWC	Bureau of Workmen's Compensation
OBES	Bureau of Employment Services
ICO	The Industrial Commission of Ohio
ODUA	Department of Urban Affairs
	Urban Development
	Council of Governments
	Office of Opportunity
	Office of Appalachia
ODH	Department of Health
	Comprehensive Health Planning

PRIVATE AND VOLUNTARY AGENCIES (Sample Listing)

ACSO	American Cancer Society
OMHF	Mental Health Federation
OARC	Association for Retarded Children
OCCHW	Citizen' Council for Health and Welfare
LHWF	Local Health and Welfare Federations

Private and Voluntary Agencies (Continued)

CCUA	Community Chests - United Appeals
GCHH	Governor's Committee on Hiring the Handicapped
OCC	Council of Churches
OEA	Education Association
OHA	Hospital Association
OMHA	Mental Health Association
OPHA	Public Health Association
ORA	Rehabilitation Association
OSCCA	Society for Crippled Children and Adults
OSDA	State Dental Association
OSHA	State Heart Association
OSMA	State Medical Association
OWC	Ohio Welfare Conference
UCPO	United Cerebral Palsy of Ohio

PLANNING ORGANIZATIONS (Sample Listing)

UD	Urban Development
OO-OA	Office of Opportunity, Appalachia
CG	City Government
CC	County Commissioners
COG	Council of Governments
MC	Model Cities
CHP	Comprehensive Health Planning
CMHP	Comprehensive Mental Health Planning
MRP	Mental Retardation Planning
HP	Hospital Planning
RMP	Regional Medical Programs
PS-HE	Primary, Secondary, and Higher Education
CAMPS	Cooperative Area Manpower Planning System
ODD	Ohio Development Department

B. The Challenge of Change

The following statement made recently to the Council of State Administrators of Vocational Rehabilitation sets forth rather directly some of the strengths and weaknesses of federal-state rehabilitation programs, and in addition, the high expectation that the rehabilitation effort or movement will continue to adjust to new and bolder challenges thrust upon it of necessity by current social problems.

"Vocational rehabilitation can make a major contribution to human resources development. Its traditional stress on the individual--plan development, counseling and monitoring individual progress, tailor-made and flexible purchase of services--uniquely equips the rehabilitation administrator to think in human resources terms. I applaud you for your past performance--up to a point. And that point is where I see that the passing years have shown no appreciable increase in the number of welfare recipients and other hard-core ghetto residents who have successfully been rehabilitated. Why is this so? When caseloads exceed available funds, does the calculus of choice favor the easy-to-rehabilitate and leave us with an ever-increasing hard-core? I wonder--and I daresay I have company in this room--whether honesty does not compel us to admit that counselors can easily maintain caseloads without seeking out those with the disadvantages of poverty. Is it unfair of Garth Mangum to say that 'despite the considerable rhetoric, Vocational Rehabilitation appears to have been less an active agent for lifting the economically disadvantaged into a more productive life than a preventive program to curtail the slippage of the disabled among the lower middle class into the poverty sub-culture'?

"And yet present law and regulations defining disability can reach so far into the area of the economically and culturally deprived--that is, the poor--that it is difficult to see how any ghetto population can reasonably be excluded from vocational rehabilitation services. While I am not privy to the debates which led to preparation of your blue bood on missions and goals, you will forgive me when I say it makes me think of a human resources coloring book: this is vocational rehabilitation, color it blue; this is welfare, color it green; this is health, color it yellow; and this is poverty, color it - well, 'related responsibilities,' and see that it is separately funded.

"The Kerner report tells us that it is time now to turn with all the purpose at our command to the major unfinished business of this nation. Strategies for action must be developed which involve all professions. We can all do with some searching of our consciences to modify our attitude towards the poor and the Negro, including the need for his participation. But then it is for you to determine whether the vocational rehabilitation program will become an integral part of broadly-based human resources programs relevant to our times I can well understand the desire of rehabilitation administrators to preserve the favorable public image of the program. But you may well have to replace humanitarianism with humanism and social justice if you are to compete successfully in the game of politics: who gets what, when, how."[1]

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[1] Irving J. Lewis, Deputy Assistant Director of the Bureau of the Budget, "Some Reflections on Politics and Administration in Social Change," (address to the 1968 Spring Meeting of the Council of State Administrators of Vocational Rehabilitation, Washington, D.C., May 1, 1968).

CHAPTER II

MASTER PLAN
Major Recommendations

"If more fully developed and supported by the States and the Federal Government, this program can be a powerful tool in combating poverty and unemployment among the millions of our citizens who face vocational handicaps which they cannot surmount without specialized help."

Lyndon B. Johnson
President of the United States
Speaking on Vocational Rehabilitation

Health Message to Congress
January, 1965

PREFACE

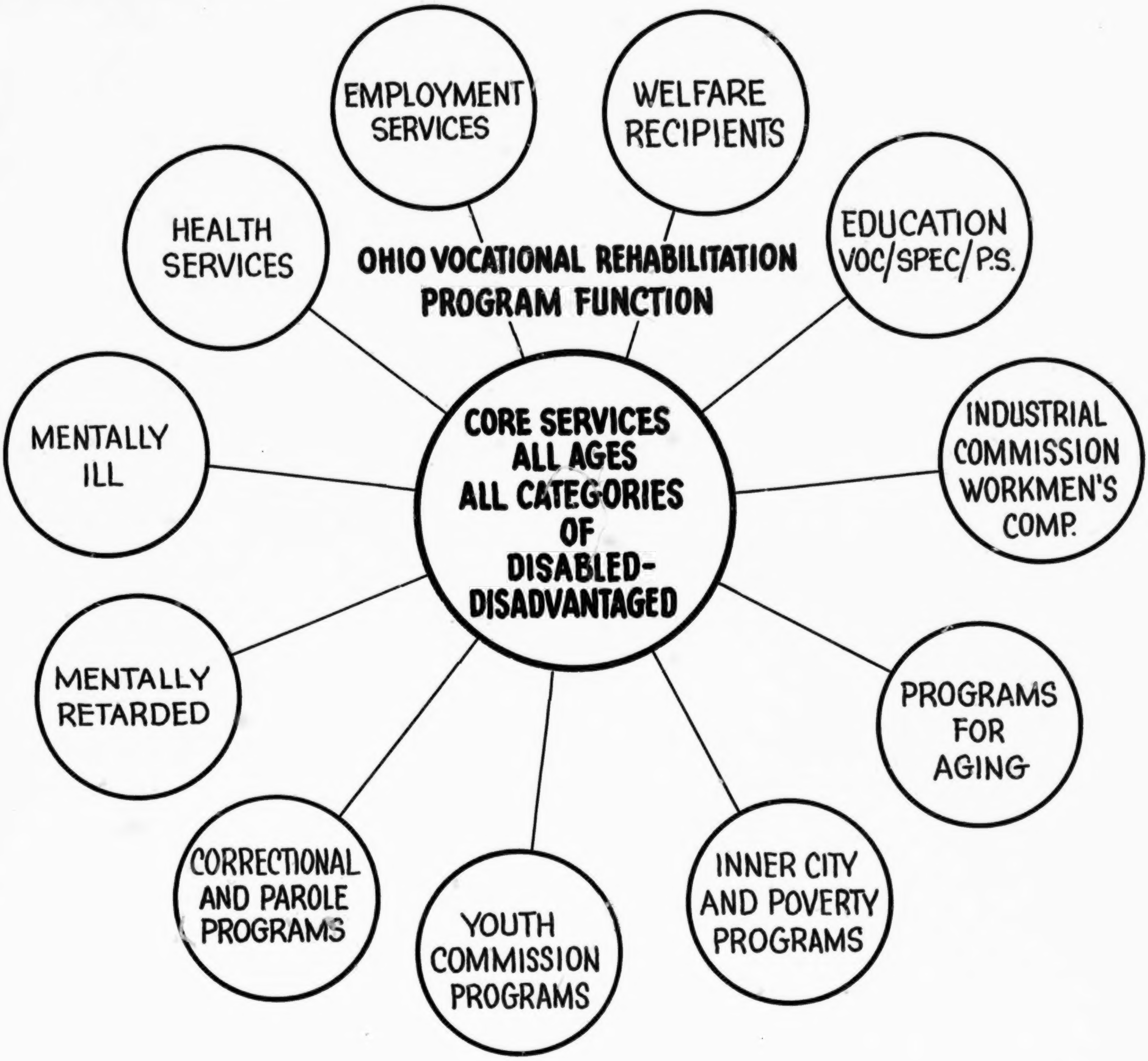
- THAT OHIO ADOPT THOSE MECHANISMS WHICH, IF ACTIVATED PROMPTLY IN TERMS OF ORGANIZATIONAL STRUCTURE, WILL MAKE AVAILABLE COMPREHENSIVE SERVICES TO ALL CATEGORIES OF THE DISABLED POPULATION IN OHIO BY 1975 OR EARLIER;

- THAT THESE MECHANISMS BE DESIGNED ON THE BASIS OF A CONTINUING CITIZEN INVOLVEMENT REPRESENTATIVE OF PROFESSIONAL AND LAY CITIZENS CONCERNED WITH THE REHABILITATION SERVICES PROGRAM;

- THAT THESE MECHANISMS BE FURTHER STRUCTURED TO INSURE CONTINUITY OF: REHABILITATION PLANNING; IMPLEMENTATION; AND COORDINATION WITH OTHER PLANNING FOR HUMAN SERVICES, e.g., COMPREHENSIVE HEALTH PLANNING, HOSPITAL PLANNING, COMPREHENSIVE MENTAL HEALTH PLANNING, AND PLANNING IN THE AREAS OF EDUCATION, MANPOWER, MENTAL RETARDATION, AND URBAN RENEWAL (MODEL CITIES PROGRAMS), etc.;

- THAT TO THIS END THE FOLLOWING ACTIONS BE TAKEN:

A STRONG FEDERAL-STATE PROGRAM EMPHASIZING: COORDINATION OF FUNDING AND PROGRAMMING FOR REHABILITATION SERVICES IN DEPARTMENTS OF STATE GOVERNMENT.



OHIO VOCATIONAL REHABILITATION PROGRAM FUNCTION

CORE SERVICES
ALL AGES
ALL CATEGORIES
OF
DISABLED-
DISADVANTAGED

EMPLOYMENT SERVICES

WELFARE RECIPIENTS

EDUCATION VOC/SPEC/P.S.

INDUSTRIAL COMMISSION WORKMEN'S COMP.

PROGRAMS FOR AGING

INNER CITY AND POVERTY PROGRAMS

YOUTH COMMISSION PROGRAMS

CORRECTIONAL AND PAROLE PROGRAMS

MENTALLY RETARDED

MENTALLY ILL

HEALTH SERVICES

FOCUS ON UNEMPLOYED AND DEPENDENT YOUTH AND ADULTS WHO SHOULD BE CONTRIBUTING TO THE STATE, FAMILY AND SOCIETY RATHER THAN CONTINUING IN CUSTODY OR SUPPORT BY THE STATE.

FIGURE 9

RECOMMENDATION ONE: OHIO REHABILITATION SERVICES COMMISSION

- THAT THERE BE ESTABLISHED THE OHIO REHABILITATION SERVICES COMMISSION, TO INCLUDE THE SERVICES AND RESPONSIBILITIES NOW UNDER THE JURISDICTIONS OF THE BUREAU OF VOCATIONAL REHABILITATION AND THE BUREAU OF SERVICES FOR THE BLIND;

- THAT THE POSITION OF DIRECTOR OF REHABILITATION SERVICES BE ESTABLISHED TO HEAD THE OHIO REHABILITATION SERVICES COMMISSION;

- THAT THE EXECUTIVE COMMITTEE OF THE GOVERNOR'S COUNCIL IMMEDIATELY NEGOTIATE WITH THE GOVERNOR AND THE DIRECTORS OF THE DEPARTMENTS IN WHICH THESE STATE REHABILITATION AGENCIES ARE PRESENTLY LOCATED, TO DETERMINE THE ADMINISTRATIVE AND/OR LEGISLATIVE ACTION NECESSARY TO ESTABLISH THE COMMISSION AND TO EFFECT THE RESPECTIVE TRANSFERS;

- THAT THE REHABILITATION PROGRAM PLANNING COMMITTEE OF THE GOVERNOR'S COUNCIL, AS OF JULY 1, 1968, IN CONSULTATION WITH OFFICIALS OF THE STATE REHABILITATION AGENCIES, IMMEDIATELY DEVELOP A JOINT PLAN BETWEEN THOSE STATE REHABILITATION AGENCIES TO EFFECT MAXIMUM EFFICIENCY, ESPECIALLY IN THE SUPPORTIVE OPERATIONS, OF THE PROPOSED REHABILITATION SERVICES COMMISSION;*

- THAT THE ESSENTIAL IDENTITY AND INDEPENDENCE OF THE BUREAU OF SERVICES FOR THE BLIND BE PRESERVED IN INTEGRATING ANY ASPECTS OF BSB OPERATIONS INTO THE TOTAL SERVICES PROGRAM OF THE REHABILITATION SERVICES COMMISSION.

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* Rehabilitation Program Planning Committee as outlined in RECOMMENDATION FIVE.

In mid-1961, Harbridge House, Inc., management consultant firm of Boston, Massachusetts, began a national survey of thirteen general rehabilitation agencies which included agencies for the blind. In their attempt to isolate and define factors contributing to the effectiveness of a state vocational rehabilitation program, they gave considerable attention to the rehabilitation agency position in state government.

The study measured the agencies' actual use of access to state government officials and the funding mechanism rather than the potential access. In the thirteen states of the national survey there was a relatively high correlation between effective use of freedom of access and funding strength. The attitudes, political awareness and skills, and activities of the agency director constituted the most important group of factors affecting program access in state government and funding success.

The position of the state agency in state government structure, however, was observed to affect the director in two ways. First, it determines the level and influence of the executive and legislative leaders with whom he has formal contact; and second, by determining at least in part his status in the government community, it affects the group of people with whom he is likely to have informal contact and influence.

At the present time the Ohio BVR and BSB represent a major $12,000,000 human services program supported by the Governor, the Legislature, and the people of Ohio. Federal funds now allotted to the State of Ohio, given sufficient state matching funds, allow for a total state agency (BVR-BSB) program capability of $37.5 million and $44.3 million in 1970 and 1971 respectively.

The projected federal funds appropriations in line with current state rehabilitation program jurisdiction would allow for at least a $60 million rehabilitation services program in Ohio by 1975. Recent national trends that advocate extension of the rehabilitation self-help concept and process to the socio-culturally disadvantaged, and to increasing numbers of those who are now welfare recipients, might affect this $60 million projection; should federal funding provisions be expanded in view of such expanded services now being planned and implemented, an even greater progression of funding beyond the projected $60 million program may result by 1975.

A state government human services program of this magnitude and complexity, designed to help people help themselves enter the mainstream of employment and/or independent living--thus avoiding costly continued assistance or custody by the state--should be clearly analyzed and adequately represented to the State Administration and the Legislature. It is improbable that any administrator of any large department of state government, already basically committed to vast administrative and funding responsibilities, could adequately review and represent to the Administration and Legislature the rapid changes and expansion in legislation, programs and funding currently characteristic of state rehabilitation programs throughout the nation.

The relative size of the rehabilitation services program funding in Ohio in comparison with that of the various departments of the state government in Ohio dealing in the delivery of direct human services;

the complexity of the rehabilitation program, both in terms of the interdisciplinary process and the many interdepartmental program relationships;

the need to clearly define rehabilitation in its various forms in other departments of state government, in addition to the state rehabilitation agencies' comprehensive services rehabilitation program, and the need to present a unified picture of the total costs and benefits of the rehabilitation programs to the Ohio Administration and Legislature;

all appear to appropriately warrant the independence of action, direct reporting and level of functional relationships afforded a commission and its director in state government.

Such visibility and access is necessary if a director is to adequately represent the total rehabilitation programs to state government officials, and achieve the successful funding of the public and private rehabilitation programs at a level commensurate with the need of those disabled and disadvantaged Ohioans who are not now being served. A minimum of 230,000 are considered eligible and feasible for these services, and if services were made available to them, would have a reasonable expectation of being placed into employment or independent living, and thus contribute to the state rather than continue dependent upon the state for subsistence.

RECOMMENDATION TWO: STATEWIDE NETWORK OF SERVICES AND FACILITIES

■ THAT OHIO ADOPT A MODEL FOR THE IMPLEMENTATION OF COMPREHENSIVE REHABILITATION SERVICES AND CORRESPONDING REHABILITATION FACILITIES TO MAKE AVAILABLE A STATEWIDE NETWORK OF SUCH SERVICES AND FACILITIES TO ALL CATEGORIES OF THE DISABLED POPULATION IN OHIO BY 1975 OR EARLIER;

■ THAT THIS MODEL INCLUDE NEIGHBORHOOD SERVICE CENTERS, SINGLE PURPOSE SERVICE CENTERS, COMPREHENSIVE REHABILITATION CENTERS, AND MULTI-PURPOSE REHABILITATION COMPLEXES AS NEEDED THROUGHOUT THE STATE TO PROVIDE A FULL RANGE OF REHABILITATION SERVICES;

■ THAT THIS MODEL BE REPLICATED IN EACH REGION ACCORDING TO THAT REGION'S NEEDS.

STATEWIDE NETWORK for REHABILITATION SERVICES

ALL SERVICES, ORGANIZATION AND INFORMATION SYSTEMS COORDINATED WITH ALL OTHER PLANNING: H.E.W./ STATE AND REGIONAL LEVELS

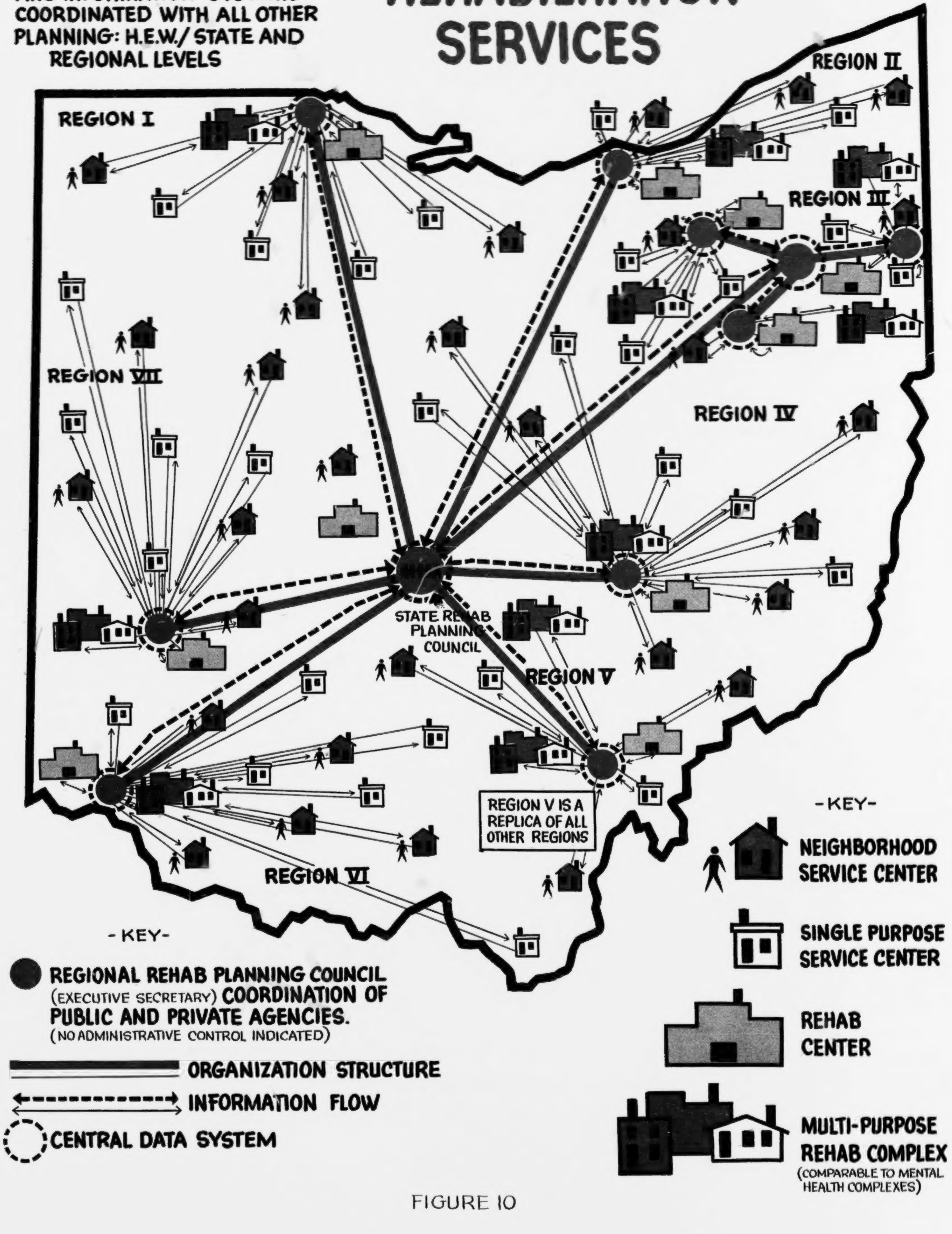
REGION I
REGION II
REGION III
REGION IV
REGION V
REGION VI
REGION VII
STATE REHAB PLANNING COUNCIL
REGION V IS A REPLICA OF ALL OTHER REGIONS
-KEY-
REGIONAL REHAB PLANNING COUNCIL (EXECUTIVE SECRETARY) COORDINATION OF PUBLIC AND PRIVATE AGENCIES. (NO ADMINISTRATIVE CONTROL INDICATED)
ORGANIZATION STRUCTURE
INFORMATION FLOW
CENTRAL DATA SYSTEM
-KEY-
NEIGHBORHOOD SERVICE CENTER
SINGLE PURPOSE SERVICE CENTER
REHAB CENTER
MULTI-PURPOSE REHAB COMPLEX (COMPARABLE TO MENTAL HEALTH COMPLEXES)

FIGURE 10

The Governor's Council recognizes that a statewide network of services must be planned to meet the needs of Ohio's handicapped; that this network of services must be based on regional needs and resources; that in each region classes of services must be spread out in a systematic way to provide comprehensive rehabilitation services in a manner commensurate with that region's unique needs and resources; that with each region replicating the model network of total services and adequate facilities, its regional network of services can best be generated by first determining which agency or agencies represent the central focus or dynamism for services in the region at present, and use this focal point as the base of concentration for the extension of its network of services throughout its geographic service area.

The Council recognizes that the central point chosen by a region for its expansion of services need not be a single agency, but might be a cluster of agencies representing a core group from which these classes of services could be generated throughout the region. The Council also recognizes the essential connection between the network of services, the network of facilities providing services, and the regional organizational framework: in providing a consensus on program development and funding, and in actually staffing the extension of the network of services throughout the region.

In recommending the adoption of a "model", the Council does not intend that the proposed model be restrictive in nature, but rather that it serve as a guideline for each region in its development of regional services and facilities to meet its unique needs through its regional resources.

The model proposed is designed so that handicapped persons in the region's communities might receive the fullest possible benefit from the specialized knowledge of those scarce, but highly skilled personnel throughout the region who are trained to provide the full range of rehabilitation related services. By clustering these specialized rehabilitation services in various types of centers, a region-wide network of services for the handicapped may be built and maintained, and specialists throughout the various communities may combine their skills toward serving all the disabled in the region.

The reports of the various disability group Task Forces throughout the state point to substantial gaps in services due to shortages of all kinds of staff and facilities. In terms of economics, it is reasonably clear that a strong multi-purpose centralized complex had decided advantages over decentralized service. There is a conservation of both facilities and staff, and the administration tends to be better. Although there are advantages to centralization, at times, service to people can suffer.

Certainly if all facilities were of centralized structure, many clients would have to be transported too far every time they needed service. Costs would be high and clients would be worn out. Consequently, the facility recommendation attempts to strike a balance between taking the client to the service and the service to the client.

A. A Functionally Integrated Network of Facilities Based on a Client-Centered Model

A long range regional plan would be to establish a coordinated system of facilities to cover the rehabilitation services required in Ohio by the physically, mentally, and socially disabled. In addition to hospitals and certain other health care facilities, four levels of facilities are envisioned with a division of labor between them based upon the most efficient use of scarce personnel and financial resources. The four levels of facilities are:

Class I Center - Neighborhood Service Centers;
Class II Center - Essentially Single or Limited Purpose Centers;
Class III Center - Rehabilitation Centers;
Class IV Center - Multi-purpose Rehabilitation Complexes.

Location of these facilities is to be based upon rehabilitation needs in an area, accessibility of the disabled to the facility, and the location of existing rehabilitation or similar type service facilities. Specific proposals for new facilities or for the modification of existing agency programs should be made in view of the master plan. Each of the types of facilities will be responsible for specific functions in the overall network.

1. The Class I Center - Decentralized Neighborhood Service Centers

The primary functions of the rehabilitation component of the Neighborhood Service Centers are:

a. Social Services

For individuals and families. Pertinent and educational information is collected in intake for case planning and possible referral to other sources. Supportive casework would also be provided as needed.

b. Vocational Guidance and Counseling

To be done by the Bureau of Vocational Rehabilitation and other trained professionals. The guidance and counseling to be provided at the site would be for those who do not need extensive services for which specialized facilities are required, or in order to act as a source of referral to the larger Class III or Class IV Centers.

c. Job Placement

This service should be provided by Ohio State Employment service and serve those clients not needing a more comprehensive rehabilitation facility service.

d. Income Maintenance Services (Public Assistance, Social Security, Unemployment Compensation)

The reason for locating these services in the neighborhood is to provide accessibility to basic income maintenance programs closer to the ongoing program of client rehabilitation, and in order for the financial aid of recipients to be planned more closely with an ongoing program of rehabilitation.

Staffing of the rehabilitation component should be based on functions performed and the need for the sharing of professional personnel among a group of nearby centers depending on caseload. As a minimum the center's rehabilitation staff would be made up of a rehabilitation team part or full time as required consisting of: Bureau of Vocational Rehabilitation -- individual case manager; social worker; counselor from Ohio State Employment Service; Public Assistance representative; rehabilitation aides - full time center staff.

Rehabilitation aides should be trained in intake and referral procedures and community liaison techniques, and work under the supervision of the rehabilitation team. Rehabilitation aides would perform the legwork and many of the recordkeeping duties for the professional staff.

A major responsibility of the Neighborhood Service Center is the involvement of the local community in the rehabilitation process. Severely disabled people often become social isolates. It will be one of the rehabilitation aide's functions to reverse this isolated process through home visits and the use of community services.

Class I Centers should be shared with other health and welfare agencies. When and if multi-function neighborhood centers are developed the rehabilitation component should be included.

The Class I Center should act as the prime source of intake for the neighborhood, and the means of referral to such other classes of centers as are selected to provide additional service.

2. The Class II Center - Single or Limited Purpose Service Center

Most facilities fall within this classification. They would include such agencies as Societies for Crippled Children, Hearing and Speech, Societies for the Blind, United Cerebral Palsy Association, Workshops for the Mentally Retarded, etc.

3. The Class III Center - Rehabilitation Center

The Class III Center provides more intensive and specialized care to the disabled who range from those with minimal involvement to those with severe involvement unable to travel elsewhere for service. All types of disabled should be accepted.

These centers will be located within the heavily populated areas on a population and accessibility basis.

The primary functions of the Class III Center are:

a. Identification of Needed Services

A determination of a program of rehabilitation for the client, tailored to his individual needs and based upon medical, psychological, social, and vocational diagnoses and evaluation, arrived at by joint consultation among appropriate professional specialists.

b. Physical Restoration Services

Based upon the recommendations of the evaluation unit and coordinated with the planned vocational rehabilitation services. These may include physical therapy, occupational therapy, and hearing and speech therapy.

c. Counseling Services

Services of vocational counselors, psychologists, and social caseworkers to contribute their special services to the rehabilitation program of the individual client.

d. Work Adjustment Services

As part of the sheltered workshop to serve as prevocational training.

e. Skill Training

To be developed in close cooperation with the vocational counseling and vocational placement staff to assure the relevance of the training as it relates to client needs and the present and future community manpower needs.

f. Vocational Placement

To work as the liaison between the center and the community to provide special placement services as needed and to develop appropriate client-centered job readiness programs.

g. Sheltered Workshop Operation

In-service training programs for center staff and for the coordination and supervision of professional training in all disciplines in the rehabilitation field.

Referrals could be made to the Class III Centers from many sources, even if the patients were still hospitalized. However, it is deemed desirable to emphasize that the Class III Center should include provision for a complete program of rehabilitation for the client, with access to services of all necessary medical personnel. An internist or generalist should be either present or readily available to serve the immediate needs of the client which arise while the client is at the center.

4. Class IV Centers - Multi-faceted Rehabilitation Complexes

It is planned that at least one such complex be located in each Region and it should be located at the central hub of a series of zones serviced by other classes of centers. These complexes should be made up of agencies which provide in-depth, long-term services to the disabled. These services would include all those services provided by the Class III Center with the addition of:

a. Intensive, Long-Term Service

Provision of services to severely disabled clients who need more intensive, long-term rehabilitation programs than can be given by the Class III Centers. This group may need long-term and in some cases, permanent housing arrangements.

b. Housing

Long and short-term housing which would permit better utilization of the facility by all the counties in the Region. Although people should be encouraged to remain in their own community and in their own families as long as possible, those whose permanent residence would not facilitate daily travel due either to distance or the nature of their disability could live in the complex during their rehabilitation program.

c. Job Development Service

This department would serve the Regional area in the development of job openings for special, hard to place disability cases. This information would be communicated to the vocational counselors and job placement specialists in the Class I Centers and Class II and III Center in their specific communities.

d. Research

To carry out evaluative research to provide information on which to base subsequent program planning and development. The coordination of small ongoing research programs in cooperation with the rehabilitation centers and the Neighborhood Service Centers would also be important.

B. Principles for Implementation

The network of services and facilities described above is outlined in detail in the Region II Report of this study. That report, in its chapter on Recommendations, encourages the adoption of fourteen principles for implementation.*

In implementing a network of services for the handicapped, it is suggested that these principles be adopted for Regional and State-level planning toward comprehensive rehabilitation services in Ohio.

Shared Responsibility

Every effort should be made to help each handicapped person feel that he "belongs" to the community as a worthwhile, contributing human being.

The system of care for the handicapped should be built with the family at the center.

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* These principles were first enumerated by the Greater Cleveland Mental Retardation Development Project. The 15 members of that project's Vocational Goals Subcommittee comprised the Mental Retardation Task Force for the Region II component of the Comprehensive Statewide Study of Vocational Rehabilitation in Ohio. Cf. "Chapter II: Recommendations," Region II Final Report.

The handicapped need all the services which a community provides to enable normal individuals and families to handle day-to-day needs -- food, clothing, shelter, medical care, education, play, work, banks, courts, insurance, transportation -- but in each instance some of the handicapped require special adaptations in order to use these resources in the community.

It is more feasible for established organizations to incorporate the necessary "adaptations" into their regular operations than to set up new organizations and facilities to offer completely separate services for the handicapped. Only when it is functionally desirable should separate services be established.

State institutions and agencies will continue to be needed but they should become partners in the community service network.

While the proposed Regional Advisory Council* should provide leadership in implementing the recommendations in this report, individual agencies and organizations also should take the initiative in developing services along the lines suggested here. This sharing of responsibility is advisable because of the size and complexity of the rehabilitation field.

Special Problems of Implementation

Professional staffing cannot be solved entirely by recruiting nationally. Personnel must be prepared locally for this work.

Since rehabilitation of the disabled and deprived is complicated and difficult, substantial additional financing will be required. Hence, every type of possible funding must be utilized.

Adherence to standards and development of quality services are essential objectives, not only in their own right but as necessary steps toward attracting financial support.

Methods for the periodic evaluation of their programs by agencies should be built into the system.

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* RECOMMENDATION FOUR.

Since much remains to be learned about the rehabilitation of the disabled and deprived and how to assist them, encouragement should be given to research proposals, demonstration projects, and other fact-gathering efforts. Findings from these studies should be shared promptly with all concerned groups and should be used to improve existing programs.

Prevention must be emphasized so as to control the future magnitude of this problem.

Buidling and Maintaining the Network

To be fully effective, a decentralized system like this requires community-wide, interagency cooperation and coordination. Responsibility for these functions should be lodged in an appropriate, community-organization agency.

Local chapters of national health agencies and other groups with a concern for the handicapped should concentrate their efforts increasingly on their advice and advocacy functions. This includes improving the public's understanding of what the handicapped can accomplish, reviewing existing services, and promoting the establishment by other community agencies of new or expanded programs, as needed.

RECOMMENDATION THREE: STATEWIDE INFORMATION NETWORK

- THAT THERE BE ESTABLISHED IN OHIO A STATEWIDE NETWORK FOR INFORMATION GATHERING, INFORMATION PROCESSING, AND INFORMATION RETRIEVAL, TO INSURE THE COORDINATED AND TIMELY DELIVERY OF REHABILITATION SERVICES TO ALL DISABILITY GROUPS, THROUGH BOTH PUBLIC AND PRIVATE AGENCY PROGRAMS;

- THAT EFFECTIVE JULY 1, 1968, THE BUREAU OF VOCATIONAL REHABILITATION AGRESSIVELY PURSUE A RESEARCH AND DEMONSTRATION GRANT FOR EXTENSIVE ANALYSIS OF INFORMATION HANDLING AND DATA PROCESSING NEEDS, BOTH IN TERMS OF STATE REHABILITATION AGENCIES' INTERNAL MANAGEMENT, AND COORDINATED EFFORTS OF ALL REHABILITATION PROGRAMS AND AGENCIES, PUBLIC OR PRIVATE, THROUGHOUT THE STATE, INCLUDING THOSE EMANATING FROM OTHER STATE AGENCIES INVOLVED IN COOPERATIVE REHABILITATION PROGRAMS THROUGH FORMAL OR INFORMAL AGREEMENTS.

- THAT THE STATEWIDE DEVELOPMENT OF THIS INFORMATION HANDLING SYSTEM BE IMPLEMENTED ON THE REGIONAL LEVEL.

The Governor's Council recognizes the integral relationship between the availability of comprehensive, adequate, current and accurate information and the efficiency with which rehabilitation services can be effectively provided. A statewide information network would serve as an additional guard against extremely rapid expansion, based on inadequate flow of information, and thus carried on without adequate controls in program development. Such controls, stemming from accurate information, are necessary for building a sound structure of program expansion.

At present there is seen to be an alarming lack of statistically accurate information regarding clients, personnel, services, and costs. Even in the recent years that have seen the application of the 1965 Amendments to the Vocational Rehabilitation Act, the attention given our present record keeping system from year to year has not noticeably improved the store of information. Indeed, population expansion and the broadening of disability categories eligible for services have made it evident, both in Ohio and in other states, that our present record keeping system is somewhat obsolete. Indications both at the state and the national level substantiate the critical importance of a more adequate data handling system to the delivery of total rehabilitation services.

Development of a central repository system as the nucleus of such a network needs to be approached with adequate planning and deliberation. It should be noted that caution has been recommended, since size alone might make such a central repository's management an extremely complex administrative function, which would be confronted with a vast network of information sources and referral points, and would evolve into an unwieldly and costly operation. A Research and Demonstration Grant for an analysis of the information processing needs in Ohio could provide that adequate, deliberate planning that might counteract these tendencies.

In developing this statewide information network, community agencies should be urged to contribute to, and benefit from such a network through the flow of data in and out of their service programs. Other state agency service programs should be enlisted in cooperative efforts to effect this statewide information handling system. It is recommended that the State Crippled Children's Program of the Ohio Department of Welfare consider expanding its filing system to identify all handicapped children under the jurisdiction of local school boards, and to include, whenever possible, information regarding the type of disability and resulting functional limitations imposed on each child so registered. The Department of Mental Hygiene and Correction is encouraged to continue to develop its information handling system and research components thereof. All state agency programs, public or private, related to the delivery of rehabilitation services are urged to cooperate with the developing statewide information network through the development of their individual, independent, central information systems.

The statewide development of this network should be implemented on the regional level. In the development by regional rehabilitation planning councils and/or individual agencies of information networks in their areas, provision should be made for intensive effort to coordinate such regional and/or local systems to insure the comparability of recorded data.

Cooperation of community agencies, and other state agency service programs, as well as the assistance of all public and private agencies related to the delivery of rehabilitation services, could result in mutual benefits. The resulting data would be valuable in providing information regarding the rehabilitation process, and characteristic disability groups that might benefit therefrom, to doctors, public school officials, leaders in business, industry and personnel management, and other key referral sources.

It is considered to be extremely important that such a system serve to strengthen the state rehabilitation agencies as the central agencies from which state-federal and local programs may be developed, and that it provide to these agencies the information necessary to give them adequate controls over funding and programming, by furnishing the bases for clear analysis of the results effected in the application of these federal and state monies.

Finally, such a network of information handling is considered the minimal essential in avoiding duplication and/or gaps in services so that well-ordered and timely delivery of services may be insured.

In the development of the entire information network, care must be taken to protect the confidentiality of information entrusted to agencies and staff members by disabled clients. It is assumed that professionals working with the development of central information and the statewide network of information handling will give such information as may be deemed confidential the same protection as is customarily demanded by their professional ethics.

RECOMMENDATION FOUR: CONTINUED ORGANIZATIONAL SUPPORT

■ EFFECTIVE JULY 1, 1968, THE GOVERNOR'S COUNCIL ON VOCATIONAL REHABILITATION BE CONTINUED IN ITS PRESENT FORM AND MANNER OF FUNCTIONING FOR THE YEAR ENDING JUNE 30, 1969;

■ EFFECTIVE JULY 1, 1969, THE GOVERNOR'S COUNCIL ADJUST TO FUNCTION AS A STATEWIDE COORDINATING BODY FOR TOTAL REHABILITATION SERVICES PLANNING, ACTING IN ADVISORY CAPACITY TO THE REHABILITATION SERVICES COMMISSION, AND KNOWN AS THE STATE ADVISORY COUNCIL ON REHABILITATION SERVICES;

■ THE DIRECTOR OF THE REHABILITATION SERVICES COMMISSION BE DESIGNATED AS EXECUTIVE SECRETARY OF THE STATEWIDE ADVISORY COUNCIL;

■ THE DIRECTOR OF REHABILITATION SERVICES ASSIGN A STATEWIDE PLANNING STAFF MEMBER, OF SOMEONE WITH COMPARABLE STATEWIDE RESPONSIBILITY ON THE REHABILITATION SERVICES COMMISSION STAFF, AS AN ADMINISTRATIVE ASSISTANT TO THE STATEWIDE ADVISORY COUNCIL TO EFFECT FOLLOW-UP;

■ EFFECTIVE JULY 1, 1968, THE REGIONAL CITIZENS' COMMITTEES BE CONTINUED IN THEIR PRESENT FORM AND MANNER OF FUNCTIONING FOR THE YEAR ENDING JUNE 30, 1969;

■ EFFECTIVE JULY 1, 1969, THE REGIONAL CITIZENS' COMMITTEES ADJUST TO FUNCTION AS REGIONAL COORDINATING BODIES FOR TOTAL REHABILITATION SERVICES PLANNING, ACTING IN AN ADVISORY CAPACITY, AND KNOWN AS THE REGIONAL ADVISORY COUNCIL ON REHABILITATION SERVICES;

■ EACH REGIONAL ADVISORY COUNCIL BE STRUCTURED TO INSURE REGIONAL COORDINATION WITH THE STATEWIDE ADVISORY COUNCIL, THROUGH THESE PRIMARY DUTIES: PROVIDING REGIONAL CITIZEN PARTICIPATION IN CONTINUED PLANNING FOR REHABILITATION SERVICES, AND EFFECTING ONGOING COORDINATION WITH PLANNING FOR OTHER HUMAN SERVICES IN THE REGION IN THOSE RELATED AREAS MENTIONED ABOVE;

■ THAT THERE BE ASSIGNED A REGIONAL PLANNING STAFF MEMBER, OR SOMEONE WITH COMPARABLE REGIONAL RESPONSIBILITY ON THE STAFF OF THE REHABILITATION SERVICES COMMISSION, AS ADMINISTRATIVE ASSISTANT TO THE REGIONAL ADVISORY COUNCIL CHAIRMAN TO EFFECT REGIONAL COORDINATION AND FOLLOW-UP.

The Governor's Council, at its meeting March 7, 1968, adopted the recommendation that the Council and the Regional Citizens' Committees be continued for a third year, recognizing that adequate organizational structure is essential to continued planning and the implementation of comprehensive rehabilitation services to meet the need of all handicapped citizens of Ohio by 1975 or earlier.

The two-year study has continually reinforced the advisability of ongoing citizen involvement in the further planning, and implementation, or rehabilitation programs to provide such services. Recommendation Four is made in light of these considerations.

RECOMMENDATION FIVE: REHABILITATION PROGRAM PLANNING COMMITTEE

■ THAT THERE BE APPOINTED A STATE-LEVEL COMMITTEE OF THE GOVERNOR'S COUNCIL EFFECTIVE JULY 1, 1968, TO SERVE AS A COMPREHENSIVE STATEWIDE MECHANISM FOR REHABILITATION PROGRAM PLANNING AND IMPLEMENTATION;

■ THAT THIS STATE-LEVEL COMMITTEE, TO BE NAMED BY THE GOVERNOR'S COUNCIL JUNE 27, 1968, BE CONCERNED PRIMARILY WITH STATEWIDE REHABILITATION SERVICES PLANNING;

■ THAT IT OPERATE INTENSIVELY IN THE NEXT YEAR AS A CONSENSUS MECHANISM TO ASSIST THE STATE REHABILITATION AGENCIES IN ASSESSING STATEWIDE REHABILITATION NEEDS AND DETERMINING PROGRAM PRIORITIES;*

■ THAT THERE BE ESTABLISHED A COMPARABLE COMMITTEE WITHIN EACH REGIONAL REHABILITATION PLANNING COUNCIL TO ADVISE AND SUPPORT REGIONAL REHABILITATION SERVICES PROGRAMS.

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* Cf., RECOMMENDATION ONE, fourth paragraph.

RECOMMENDATION SIX: LEGISLATION AND FINANCE COMMITTEE

■ THAT THERE BE APPOINTED A STATE-LEVEL LEGISLATION AND FINANCE COMMITTEE OF THE GOVERNOR'S COUNCIL EFFECTIVE JULY 1, 1968, TO SERVE AS A COMPREHENSIVE STATEWIDE MECHANISM TO INSURE IMPLEMENTATION OF THIS REPORT WITH EQUITABLE AND ADEQUATE FINANCING INTO THE PUBLIC AND PRIVATE SECTOR REHABILITATION PROGRAMS ON A CONTINUING BASIS;

■ THAT THIS STATE-LEVEL COMMITTEE BE NAMED BY THE GOVERNOR'S COUNCIL JUNE 27, 1968;

■ THAT ITS FUNCTION BE GIVEN THE HIGHEST PRIORITY;

■ THAT THE COMMITTEE BEGIN ITS WORK AT ONCE, AND COORDINATE ITS EFFORTS CLOSELY WITH THE MANAGEMENT PERSONNEL OF THE STATE REHABILITATION AGENCIES, CONCURRENTLY SETTING UP SYSTEMATIC COMMUNICATIONS WITH THE STATE DEPARTMENT OF FINANCE, AND DEPARTMENTS OF STATE GOVERNMENT DESIRING AND CAPABLE OF ENTERING INTO COOPERATIVE AGREEMENTS FOR JOINT FINANCING AND COOPERATIVE REHABILITATION SERVICES PROGRAMMING;

■ THAT THE PRIMARY, ESSENTIAL ASSIGNMENT OF THIS COMMITTEE BE TO DETERMINE NEEDED LEGISLATION AND ADEQUATE FINANCING AT A LEVEL THAT MAY BE EFFECTIVELY IMPLEMENTED BY STATE OPERATIONS AND THE PUBLIC AND PRIVATE SECTOR PROGRAMS, GIVEN MAXIMUM EXPANSION OF SERVICES, DURING THE BIENNIUM 1969-1971; TO INSURE MAXIMUM POSSIBLE UTILIZATION OF AVAILABLE FEDERAL MATCHING FUNDS BY SEEING THAT STATE-SHARE FUNDS ARE MADE AVAILABLE AT THAT MAXIMUM LEVEL FOR WHICH APPLICATION OF THE RESULTING FEDERAL-STATE FUNDED BUDGET FOR REHABILITATION SERVICES CAN BE ASSURED THROUGH PROGRAM EXPANSION;

■ THAT THERE BE ESTABLISHED A COMPARABLE COMMITTEE WITH EACH REGIONAL REHABILITATION PLANNING COUNCIL TO ASSIST REGIONAL REHABILITATION SERVICES PROGRAM DEVELOPMENT IN COORDINATION WITH THE GOVERNOR'S COUNCIL COMMITTEE ON LEGISLATION AND FINANCE AT THE STATE LEVEL.

Recommendation Five and Six call for two Committees within the overall Governor's Council -- Regional Citizens' Committee structure, each to be established at both statewide and regional levels; one to act in an advisory function in the area of rehabilitation program planning; the second to act in advisory function in the parallel responsibility for funding.

Both of these Committees would serve, basically, as means for obtaining and making known the consensus regarding these two areas, so that state rehabilitation agencies might have a stronger basis for setting up priorities and for planning in an equitable manner.

These two Committees should be structured in such a way as to coordinate the development of total regional programs and state planning to avoid wasteful duplication and enhance the possibilities for obtaining the necessary funds to effect such programs.

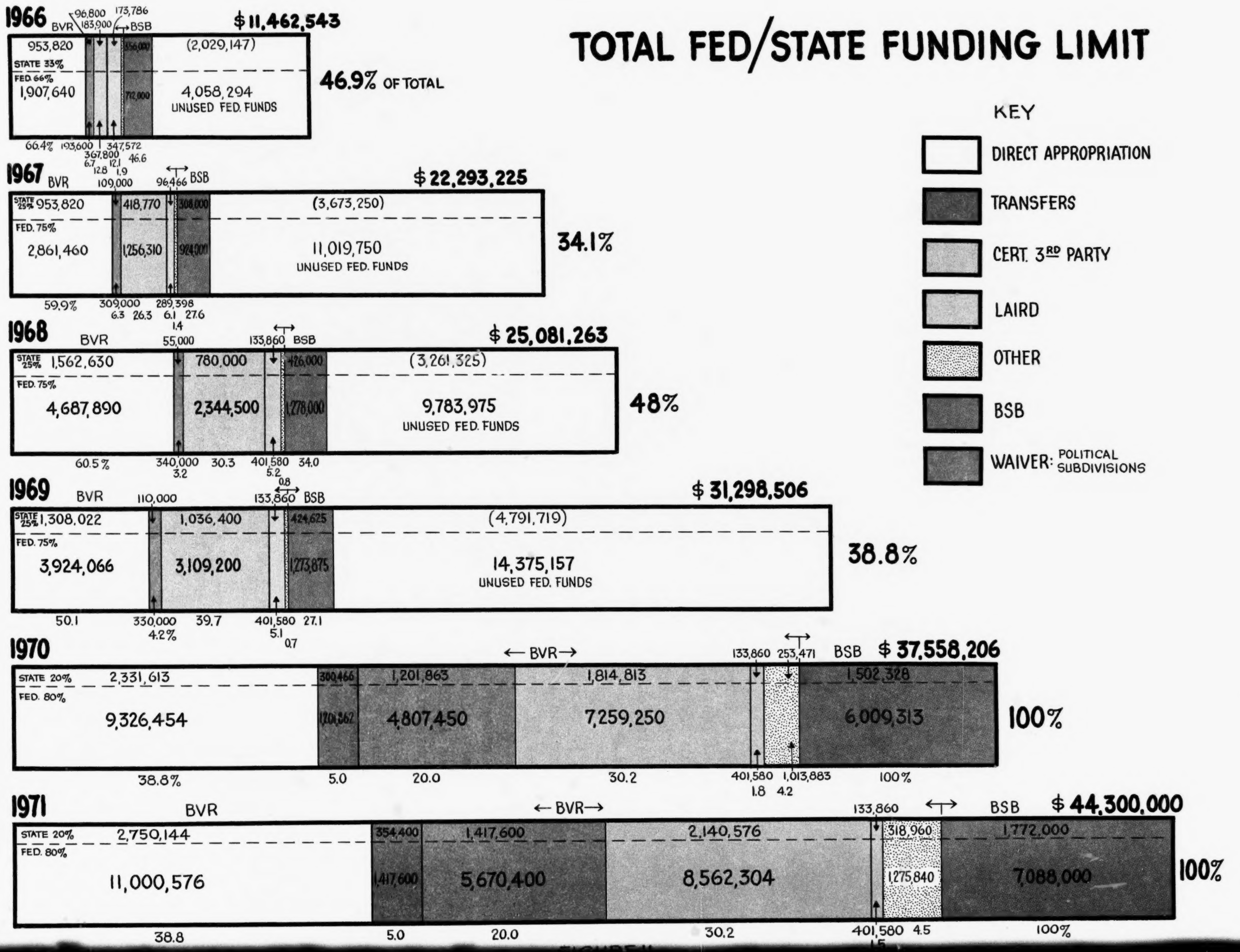
It would not be the purpose of these Committees to have any authority that would interfere with the operational functions properly the domain of state rehabilitation agencies or of private agencies. It would not be their prerogative to screen out proposals, nor to interfere with the right of any agency, public or private, to deal directly with the state rehabilitation agencies on behalf of program development through federal funding.

It is recommended that those coordinators in program development planning who are at present part of the staff of the state rehabilitation agencies be assigned to act as consultants to these Committees.

Recommendation Six implies guidelines for fiscal control. The federal laws and regulations governing the administration of rehabilitation programs in the state have allowed for a unique flexibility in funding. It is possible for state vocational rehabilitation agencies to be experimental and innovative, as well as extensively develop the core operational programs, by entering into a variety of cooperative interdepartmental programming and funding agreements. This flexibility in funding is, on one hand, a definite asset in getting maximum efficient utilization of all rehabilitation services sponsored by a state government; however, at the same time, this flexibility lends itself to complexity and certain hazards for a total state agency rehabilitation services program.

It is thus essential to establish, by general policy, a formula by which the state agency and its advisory council may prevent exclusive or over investment in any given category of disability, or disproportionate concentration on a given age group.

TOTAL FED/STATE FUNDING LIMIT



This formula is suggested as a general guide for the state rehabilitation agencies and their advisory committees:

SUGGESTED FORMULA

	% of Agency Budgets	
	1971	1972
Federal Matching Funds + State Certified 3rd Party Funds	30.2	30.2
Transfers	20.0	20.0
Gifts/Refunds (other)	4.2	4.5
Laird Amendment	1.8	1.5
Waiver of Statewideness	5.0	5.0
Direct State Appropriation	38.8	38.8

Such state rehabilitation agency program imbalance is especially fostered and acute with regard to the certification of state expenditures from programs of various departments of state government. These certifications represent expenditures in existing facilities such as mental hospitals, correctional institutions, etc., and for professionals salaried by those departments of state government giving all or a percentage of their time and other related expenses. It is contended by some officials in state government that these are expenditures or investments by state government in rehabilitation; that one should therefore encourage an extensive policy of certification of existing space and professional time for matching purposes with available federal funds. However, overextension of funding by the certification method imposes serious budgetary control problems and legal complexities on the state rehabilitation agencies which restrict the development of services to special groups in addition to hazarding the mandate of the state rehabilitation agencies to provide comprehensive services to a broad range of disabilities and age groups.

By aggressively pursuing sources of state matching funds, invested or potentially to be invested in rehabilitation services in other departments of state government, the formula has provided for 61.2 percent of the total state-federal program budget for 1970, from sources (as illustrated above) other than direct appropriations from the Ohio Legislature to the state rehabilitation agencies. Those familiar with the funding requirements of the state rehabilitation agency programs feel that at least 38.8 percent of the total state-federal rehabilitation budget for 1970 must come from direct appropriations, and that this percentage would be minimal since 50 percent in direct appropriations would more realistically provide adequate flexible services in the community-based core rehabilitation programs throughout Ohio which service all categories of disabled and all age groups.

This basic program of core services administered to all categories of disabled of all ages must be developed concurrently and proportionately with those special rehabilitation programs designed to meet the needs of certain categories such as the emotionally ill, mentally retarded and public offender, etc. The success of institutional programs is quite dependent upon the follow-up assistance and re-evaluation offered to those released from institutional type programs, through the community based rehabilitation program.

CHAPTER

III

SPECIFIC RECOMMENDATIONS BY STUDY CATEGORY

"I believe that the final outcome of America's growing affluence, of our great investments in health, education, in social security and social services, will be to offer each individual a greater freedom of choice of what he may do with his life. And this is a freedom of choice that must extend to all of our people throughout their lives and give greater meaning to their lives."

Wilbur J. Cohen,
Under Secretary of Health, Education, and Welfare
Social Policy for the Nineteen Seventies, May, 1966

STUDY CATEGORIES AND CHAPTER PLAN

This chapter will present recommendations designed to meet those major needs documented throughout the state as having priority in each category of study. It must of necessity remain broad enough in scope to allow regional planners the authority and responsibility for local implementation.

More detailed guidelines to effective local action are to be found in each of the seven Ohio regional reports. These reports will be available in their respective regions to rehabilitation agencies and professionals, and those interested persons, professional and lay, in other disciplines and community programs, to guide community and regional planning toward step-by-step implementation.

A. Areas Explored in Ohio's Regional Studies

As part of the two-year comprehensive statewide study of vocational rehabilitation needs and resources in Ohio, individual task forces in each planning region investigated six major study categories: manpower; interagency coordination; facilities and workshops; physical disabilities; mental disabilities; and social disabilities.

Task force reports throughout the state made repeated reference to several additional concerns. These are relevant to all six study areas, and appear vital to the total planning for vocational rehabilitation services. They relate to needs in the areas of: state agency administration; public education; business and industry involvement; and on-going planning. As task force study reports from each region were reviewed by Statewide Ad Hoc Committees, the critical nature of the needs in these four areas became apparent from the frequent recurrence of specific task force recommendations toward meeting them.

The study members showed special concern toward two specific classes of Ohio's disabled and disadvantaged population: the aging and the deaf/hard of hearing. An Ad Hoc Committee on the Aging made specific recommendations based on their study of rehabilitation needs of Ohio's older citizens. A Subcommittee on the Deaf formed in Region I submitted recommendations which were supported by findings in the other six regional studies of persons with hearing and speech-related disabilities. Recommendations related to these disability groups are among those to be included in this chapter.

Task force findings led to specific recommendations regarding two major categories of service: intake and placement. These, too, will be presented because of the special problems related to: making the potential client aware of the services available to him; educating persons most likely to come into contact with the potential client to the program of vocational rehabilitation services, thus encouraging more comprehensive and more adequate referral sources; and eliminating the many barriers to placement that keep the rehabilitated client a largely untapped source of manpower within the Ohio labor market.

B. Developing Specific Recommendations in Study Categories

The regional task force reports were submitted to six Statewide Ad Hoc Committees, one in each particular area of study investigated by the regional task forces. These Statewide Ad Hoc Committees on Manpower, Interagency Coordination, Facilities and Workshops, Physical Disabilities, Mental Disabilities, and Social Disabilities studied the regional task force recommendations in their particular area to determine statewide needs and their priority. Specifically, the Statewide Ad Hoc Committees were charged with drawing from the regional reports evidence regarding general priority needs that were common to all seven regions; and outlining those specific recommendations in their study category which would treat a problem rather than its symptom, would have a broad base and wide implications, and, if implemented, would allow for the carrying out of the more detailed recommendations proposed in that category of study by each region's task force.

This chapter draws from regional task force findings and recommendations in stating the specific major emphases and recommendations of the six Statewide Ad Hoc Committees.

C. Order of Presentation

In the pages that follow, needs related to state agency administration, public education, business/industry involvement, and continuation of planning will be considered first. These have overall importance in setting a favorable climate and in preparing those planning/administration structures conducive to the most efficient and effective delivery of vocational rehabilitation services.

Next, attention will be given to the specific categories of study undertaken by the Task Forces, and recommendations that evolved from each, including needs in:

manpower recruitment, training, retention, and utilization;

interagency coordination through communication, coordination of planning, and cooperation in the delivery of services;

facilities and workshops and their development and utilization in relation to the model of services recommended in the Master Plan (Chapter III);

the needs of the physically disabled, including the special needs of the deaf/hard of hearing;

services to the mentally disabled and close coordination of planning with Comprehensive Community Mental Health Planning in Ohio;

the needs of the relatively new category of socially disabled, with special recommendations concerning the vocational rehabilitation of the aging; the public offender; the alcoholic and the drug addict; economically deprived and hard-core unemployed.

In conclusion, attention will be given to those categories of service that mark the inception and the ideal outcome of rehabilitation services to the disabled and disadvantaged:

acceptance for service of greater numbers of clients in need of rehabilitation services, through information efforts directed toward potential clients, and improved relations with potential referral sources;

successful placement of the client into a vocational objective and, when that vocational objective is employment, increased hope for his placement into such employment through elimination of the many barriers now facing the disadvantaged and disabled in their search for job opportunities.

ESTABLISHING CONDITIONS THAT WILL ENHANCE DELIVERY OF SERVICES

Those administrative differences and jurisdictional delays that can arise from parochial or fragmented approaches to human services are nearly always incompatible with the client's best interests. To minimize these negative influences, regional task forces repeatedly made recommendations dealing with broad areas of concern that properly describe the most appropriate setting for efficient and effective delivery of rehabilitation services, namely, those internal (rehabilitation agency/profession) and external (community) conditions that provide an ideal climate for the carrying out of rehabilitation services in the manner most suited to serving the client's best interests.

A. State Agency Administration of Rehabilitation Services Programs

One such set of conditions is to be found in those factors characteristic of state agency administration of rehabilitation services programs. The Governor's Council on Vocational Rehabilitation contracted with Harbridge House, Inc., of Boston, Massachusetts, to conduct a detailed investigation of state agency operations and to publish an assessment of agency performance in the light of findings of their investigation.

Findings and recommendations regarding agency administration are given here as extracted from the overall Harbridge House report. There follow some specific recommendations made by regional task forces relative to agency operations.

The materials in this section should be studied in relation to the first recommendation of the Governor's Council, pertaining to the establishment of the Ohio Rehabilitation Services Commission as an independent agency of state government.* This recommendation varies from those contained in the Harbridge House assessment in three major details:

it presents an independent Commission, to include services of both BVR and BSB, as the more viable way of assuring the coordination of many rehabilitation services now offered throughout various agencies of state government into a more comprehensive, cohesive pattern of services, so that rehabilitation becomes at once more comprehensible to the public and more readily subject to legislative and fiscal jurisdictions of the governor and legislature of the state:

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* RECOMMENDATION ONE (Chapter III: Master Plan - Major Recommendations).

it establishes the position of director to serve as executive head of the Commission;

it calls for preservation of the essential identity and independence of the Bureau of Services for the Blind in integrating any aspects of that agency's program into the comprehensive program of services of the Commission.

In most other respects, the recommendations made by Harbridge House can provide valuable guidelines for the implementation of Governor's Council recommendations as they pertain to state agency administration of vocational rehabilitation programs.

1. Agency Performance: Harbridge House Assessment

The Bureau of Vocational Rehabilitation in the Department of Education and the Bureau of Services for the Blind in the Department of Public Welfare have the primary mandate for providing rehabilitation services in the state. Although many other public and private agencies have a major role in the program, the BVR and the BSB should be the principal focal point and the primary source of statewide leadership in the planning, development, and delivery of services to the handicapped.

On balance, the two agencies have not met the challenge. Relative to other state rehabilitation agencies in the Middle West and in the nation, they rank among the lowest in most measures of performance. For example, in the number of successful rehabilitations per 100,000 population -- a measure of productivity -- the state has regularly alternated between 51st and 52nd in the national rankings. While the national average per state has increased from 58 rehabilitations per 100,000 in 1963 to 87 in 1967, Ohio has increased only from 27 to 39. In per capita funding -- a measure of available resources -- Ohio ranks 53rd in the nation.

The present level of service appears to be wholly inadequate to the need. The Statewide Planning staff has made a preliminary estimate of 230,000 people as the subpopulation to be served. Assuming an annual increment of 10 to 15 percent of this figure, representing newly disabled clients, this estimate implies an increase in annual rehabilitations on the order of five to seven times.

Both agencies are serving a caseload that is small in relation to the need, and their caseloads are apparently weighted in the direction of relatively easy cases. For both agencies, the caseload is younger, better educated, and more heavily weighted toward males than the national average. Given the limited funds that are available to the agencies, this selectivity of caseload is understandable and perhaps even justifiable. It is not, however, a matter of agency policy, and it runs counter to the comprehensive mission of the vocational rehabilitation program -- to serve all the handicapped, regardless of difficulty or severity.[1]

2. The Rehabilitation Program in Ohio: Harbridge House Recommendations

Organization

Transfer BVR and BSB to the Department of Mental Hygiene and Corrections.

Rename the Department: Rehabilitation and Institutional Services or Department of Human Services.

Create a Division of Rehabilitation Services to include both BVR and BSB.

Establish the position of Commisioner of Rehabilitation Services to head the new division. This position should have tenure and adequate compensation. It should be filled by a nonpolitical panel. Qualifications should include the following:

substantial administrative experience in vocational rehabilitation or a similar program.

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[1] "Part III. The Rehabilitation Program in Ohio," *Assessment of Agency Performance: Bureau of Vocational Rehabilitation, Department of Education; Bureau of Services for the Blind, Department of Public Welfare* (Boston: Harbridge House, Inc. March 1968), p. III-1.

demonstrated competence in a leadership role.

experience in working in or with government, preferably at the state level.

familiarity with and professional acceptance by community resources related to rehabilitation programs.

academic achievement beyond the B.A. degree, preferably in rehabilitation or administration.

Establish the following as central services, reporting to the Commissioner, in support of both the BVR and the BSB:

Medical Administrative Consultant.

Administrative Services -- Personnel and Staff Development, Fiscal, Statistical, and Purchasing.

Program Development and Special Services -- Disability Specialists, Facilities and Workshops, Field Consultants.

Provide common housing and administrative support for BVR and BSB staff in the district offices.

Assign program planning, monitoring and review responsibility for both BVR and BSB field operations to the Regional Supervisors.

Funding

Establish a continuing comprehensive program research capability to maintain continuing analysis of program needs and gaps or deficiencies in service. This can be done through assignment of one or more program analysts to the Commissioner for Rehabilitation Services, with support as required from Administrative Services and Program Development and Special Services.

Develop a comprehensive continuing public information program tailored to program objectives and to community support groups. The Public Information function should be assigned to the Commissioner of Rehabilitation Services.

Establish the Governor's Council for Vocational Rehabilitation as a permanent advisory body to the BVR and the Commissioner of Rehabilitation Services, replacing the State Board of Education in this role.

Retain the regional committees as Regional Advisory Councils, with members of the Governor's Council as ex officio members.

Establish counterpart Regional Advisory Councils for the Commission for the Blind.

Develop a system for economic justification of the program, including:

analysis of past program benefits in terms of "Return on Investment" or cost-benefit relationships -- earnings of rehabilitants, taxes paid, savings on welfare payments and institutional costs, and so forth.

cost-benefit analysis of alternative programs and patterns of service.

Analyze potential sources of additional funds to determine present level of usage and potential increases, if any, including:

Social Security Trust Funds.

Medicare and Medicaid.

Manpower Development and Training Act.

Ohio State Employment Service Selective Placement.

Place increased emphasis on development of innovation and expansion projects.

Develop a coordinated public information program designed to foster increased community and political support, including:

local and regional data on program benefits, including "Return on Investment."

increased participation by state legislators and other elected officials in program affairs -- advisory committees, opening ceremonies for new units, and so forth.

Develop opportunities for cost savings through standardized service "Packages" and minimum guarantees with institutional and non-profit suppliers of services.[1]

3. The Bureau of Vocational Rehabilitation: Harbridge House Recommendations

Relations with the Department of Education

Develop a program for increased communication with the Department and its components:

provide information on the ongoing program and opportunities for cooperative programming.

provide information and opportunities for research on client characteristics, educational needs, and problems.

make increased use of departmental professional services, such as training of BVR staff in the use of psychological testing or techniques of vocational evaluation.

seek Department support for increased funding.

develop a joint plan for making the transfer from Education to Mental Hygiene and Corrections.

Organization Structure

Make the following organizational changes in the State Office:

place first priority on filling Field Analyst vacancies in Field Services, initially through waiver of requirements and ultimately through revision of requirements.

eliminate the requirement that Field Analyst vacancies be filled before the Acting Assistant Director, Field Services, can be advanced to permanent status.

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[1] "Part II. Summary of Recommendations," Assessment of Agency Performance, pp. II-1 ff.

disband the Ad Hoc Task Force.

transfer the Staff Development function from Field Services to Administrative Services.

assign all Disability Specialists to Program Development and Special Services.

redefine the responsibility of Program Development and Special Services to include only the functions of program planning and development, and the provision of technical consultation.

transfer field supervisory responsibility for existing cooperative units from Program Development and Special Services to Field Services.

transfer one Unit Coordinator vacancy from Program Development and Special Services to Field Services.

establish criteria and procedures for the assumption by Field Services of supervisory responsibility for newly established units.

establish procedures for coordinated review of workshop and facility needs of all field units and offices.

reexamine the systems and procedures of Administrative Services to increase productivity and timeliness of its support function.

establish instructions and formats for analysis of statistics.

upgrade the Purchasing function to a full-time activity, equivalent in status to Finance and Statistics, in Administrative Services.

transfer the Public Information function from Administrative Services to the Office of the Director.

transfer the Rehabilitation Advisor from Administrative Services to Field Services.

assign responsibility for intra-agency liaison and development of the State Plan to the Systems Coordinator.

Make the following organizational changes in field operations:

define the responsibilities of Regional Supervisors to emphasize overall coordination, review, analysis, and development of regional services.

provide the Regional Supervisors with public information and program analysis staff, part-time or full-time.

develop plans for establishment of "Metro-Regions" in major metropolitan centers, each with a Regional Supervisor and several district and unit offices.

attach new field units to district offices temporarily, for supervision and staffing, using senior counselors as Acting Unit Supervisors.

adopt a policy prohibiting field supervisors from carrying caseloads.

transfer all authority for plan approval from Regional Supervisors to District Office Supervisors.

Internal Communications

Develop a system for communicating interpretation and clarification of policy and procedure to all BVR staff.

Staff Recruitment and Development

analyze staff turnover to determine causes and develop preventive measures.

plan staff acquistions to keep the proportion of new and inexperienced personnel in any location to a predetermined maximum.

request enabling authority to pay moving allowances.

initiate with the Ohio Department of State Personnel a joint study of policies and practices regarding state agency bars to employment of individuals with disabling conditions to determine handicapping limitations that affect job performance.

develop a system for individual performance evaluation, with criteria and standards related to specific job requirements, covering supervisors, counselors, and nonprofessionals.

Develop a plan for inservice training, based on specific training needs, to include:

intensive short-term training in supervisory techniques and practices, for all present supervisors and near-term candidates.

a planned program for selection of personnel for university training programs.

a planned program for training of supervisory and clerical staff in coordination with the addition of newly trained VR counselors.

broaden the scope of available university training sites and programs.

develop seminars for orientation to the BVR program of outside groups with a direct interest -- for example, institutional personnel, Ohio State Employment Service counselors in selective placement activities, and personnel officers in public and private organizations.

Planning and Control

Develop the Management by Objectives system to a greater degree of effectiveness by:

providing Statewide Planning guidelines for the development of local, regional, and state program plans.

provision of adequate time for preparation of regional, district, and unit plans.

more precise definition of goals and programs, in terms of targets, costs, and measures of accomplishment.

establishment of responsibility for meeting goals.

establishment of uniform format for plans and progress reports.

development of plans by all State Office components.

coordinated review and approval of field and State Office plans.

systematic reporting and review of progress.

integration of program plans with budget submissions, and development of long-range plans in alternate (non-budget) years.

Establish an automatic interim allocation system to hold expenditures and encumbrances in a new fiscal year until the legislature authorizes an increase.

Establish a procedure for reporting of encumbrances that are prepared but suspended until the close of the fiscal year, to insure that offsets against the next year's appropriations can be made and that the planned encumbrances are compatible with overall funding and program plans.

Establish a time limit (two working days, if possible) for reporting disencumbrance of funds for plan amendments and for clients closed in Status 28 or 30.

Establish a procedure for developing financial estimates for policy and procedural changes.

Develop a system for analysis and control of estimates, budgets, and certifications in programs that involve third-party funding.

Develop detailed guidelines for establishing, developing, and operating cooperative units.

Develop a system for monitoring and controlling caseload progress and financial operations at the counselor, district or unit, region, and state levels.

Develop financial agreements with nonprofit vendors and suppliers of services for minimum guarantees and standard service packages.[1]

4. The Bureau of Services for the Blind: Harbridge House Recommendations

Relations with the Department of Public Welfare

Develop a program for increased communication with the Department and its components, including provision of information on program activities and solicitation of help on problems.

Seek Department support for increased funding.

Obtain increased coordination and cooperation from departmental supporting services, including:

provision of fiscal and statistical information.

agreement on overhead allocations.

agreement on program accounts and charges to be made thereto, including prior advice on proposed amendments or changes.

more suitable quarters.

Transfer responsibility for supervision of clerical personnel from departmental Deputy Directors to the BSB District Office Supervisors.

Develop a joint plan for making the transfer from Welfare to Mental Hygiene and Corrections.

Organization Structure

Define the responsibilities of the VR Supervisor to emphasize overall review, analysis, coordination, and development of program services.

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[1] "Part II. Summary of Recommendations," Assessment of Agency Performance, pp. II-4 ff.

Establish a salary differential between the positions of the VR Supervisor and the District Office Supervisors.

Delegate authority to the District Office Supervisors for:

client plan approval.

hiring of professional and clerical staff.

Establish a routine procedure for provision of information on Federal standards and regulations to District Office Supervisors.

Establish a full-time Staff Development Specialist's position.

Analyze alternative methods and resources for increasing the supply of mobility and personal adjustment services, either through additional staff or purchase of services on a guaranteed basis.

Establish an expanded career development program for home teachers and BES counselors.

Eliminate the intermediary role of the public health nurses between the VR counselors and the medical and opthalmological consultants.

Develop plans for more balanced geographic distribution of district and branch offices.

Staff Development

Determine short - and long-term requirements for additional staff.

Develop a system for evaluation of individual performance, with criteria and standards related to specific job requirements, for professional and clerical staff.

Develop a plan for inservice training, based on specific training needs.

Develop a comprehensive orientation program to acquaint counselors with existing resources and procedures.

Make fuller use of the Kent State University counselor training program.

Provide training for VR counselors, on a high priority basis, in the use of medical and opthalmological consultants.

Develop special career training programs for home teachers and BES counselors.

Planning and Control

Develop a planning and control system modeled on the BVR Management by Objectives system, with recommended changes and improvements.

Establish district office budgets, with an accompanying system for controlling allocations, encumbrances, and expenditures.

Develop a system for monitoring and controlling caseload progress at the counselor, district, and state levels.

Develop a system for review and analysis of case services and costs, particularly for closed cases. The system should include, if possible, segregation of time for home teacher and public health nurse services to clients, in order to improve measurement of VR counselor productivity.

Develop standard service "packages" and minimum guarantees with major nonprofit vendors and suppliers of services.[1]

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[1] "Part II. Summary of Recommendations," Assessment of Agency Performance, pp. II-8 ff.

5. Study Recommendations: State Agency Administration

Throughout the regional reports of the comprehensive statewide study of vocational rehabilitation in Ohio, recommendations -- some broad and general, others quite specific -- were included in the various Task Force reports, yet dealt with the more inclusive component of rehabilitation programming properly referred to as state agency administration.

These recommendations are summarized here as a complementary adjunct to previous materials in this section.

Case Finding

Main efforts in case finding should be made through regular rounds of contacts with such referral sources as welfare agencies, hospitals, school systems, physicians, to:

find potential clients early, before they become fixed in their disabilities;

remind such referral sources of services available through the state rehabilitation agency administration of service programs;

search out and serve a continuingly greater proportion of the disabled in Ohio.

Consultation and Review

Periodic meetings should be held to review with the Field Medical Consultants, and whatever additional staff consultants in parallel service specialties may be developed in the future, such accomplishments and failures as have been noted in client services. More frequent communications as to the causes contributing to successes, and the location and possible causes of client-service failures, may strengthen areas in which weaknesses become apparent and thus lead to improvements in service.

Information Filing and Record Research

A suitable card file or "tickler" file system should be set up for record research. It should be used to review periodically, the active case file; the old cases that have been temporarily or permanently closed; and some of the rehabilitated cases; with the purpose of such review being to determine whether there are new approaches that might be tried; whether new services might be available to those we have been unable to serve in the past; and to determine efficient and economical ways of further expanding such services to those who need them.

Follow-Up Studies

Follow-up studies should be made of participants and non-participants in the state agency rehabilitation program to assess the relative merits of the program in terms of its long-range efficacy.

Client-Centered Approach

The state rehabilitation agency should take whatever steps necessary to become less "closure-oriented", through increasing staff and realignment of duties, so that "closure conscious" counselors may become "client conscious" through state-agency encouragement toward quality service to all classes of severity in handicapping conditions, with less emphasis on the quantity of closures as the major criterion in measuring professional adequacy.

B. Development of Community Support Through Public Education

One of the most basic of those several conditions necessary to allow rehabilitation, with all its ramifications, to take place, is public awareness and strong community support for the rehabilitation concept as a valid approach in overcoming handicapping conditions and restoring the disabled and disadvantaged citizen to independent living, self-respect, and a contributing role in the community.

"The scope of a rehabilitation program is strongly influenced before referred persons come to the state VR agency.

This is true because the relationship that a VR agency has with its sources of referral, and the image that the community has of its services, will determine who is sent to the agency. It will also determine which disabled people will go to the agency on their own, since an individual does not automatically acquire new concepts when he becomes disabled. His decision to go, or not go, to the VR agency for help will be largely determined by how he previously thought of the agency -- or if he ever heard of it."[1]

1. The Need for a Strong Public Relations Emphasis

The proportion of citizens who "never heard of it" is unfortunately all too high. The rehabilitation story as personified in the growth and development of services available to Ohio's handicapped, and as dramatized by the needs of the handicapped not yet receiving such services, has not been made known to the general public.

Within the past year, a thirty-minute film, "For People Too", developed and produced by the Bureau of Vocational Rehabilitation with the cooperation of the Governor's Council and its Regional Citizens' Committees, has endeavored to tell the story of the comprehensive statewide study. Sponsored by Motorists Mutual Insurance Company, the film attempted to emphasize the values inherent in the total rehabilitation services concept by showing actual benefits of such services to specific clients who became economically productive when placed in a suitable occupation, or who achieved independent living even though unable to compete in the labor market.

The cooperation of many television stations throughout Ohio in showing this film is indeed encouraging. Yet this is, at most, a good beginning. It is generally conceded that "steady, long term information accomplishes more for positive program images than spectacular or one-shot attempts. Although the latter can have considerable value, especially for specific purposes, they should be in addition to steady overall public relations; and, most important, they should fit congruently within an over-all public relations program."[1]

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[1] Martin Dishart, Ph.D., Vital Issues and Recommendations From The 1965 National Institutes for Rehabilitation Research (Washington: National Rehabilitation Association, 1965), p. 33.

2. Components of a Public Relations Program

Inherent in any program of public education and information is the assumption that suitable, accurate, and current data regarding the subject are available to those wishing to make the public aware of its importance.

Thus, the network of information gathering, information processing, and information retrieval recommended by the Governor's Council (RECOMMENDATION THREE -- Chapter III: Master Plan), while having critical relevance to interagency coordination for effecting a statewide network of rehabilitation services, is also vital to the carrying out of an intensive public education program to gain the support of the community, and of business and industry, for the rehabilitation concept and its goal.

Using the developing information network as a base for factual reporting to the public, an ongoing public relations program should be developed to inform professional and lay citizens alike of the needs of the disabled, and the nature of the total rehabilitation services concept in planning for coordinated human services to meet these needs.

Since its beginning in 1966, the Public Information Section of the Bureau of Vocational Rehabilitation has made marked progress toward initiating a public relations and public information orientation among rehabilitation professionals. Yet the two professional staff members charged with this vast responsibility cannot be delegated the total obligation.

The ongoing public relations program should exist at the local, regional, and state levels alike; it should be adequately staffed at each level, with an understanding and commitment on the part of each person working in the field of rehabilitation relative to the public relations aspect and opportunities in his specific staff function, in addition to the formal public relations program as it exists in his agency or community.

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[1] Ibid., p.34.

Such a program should endeavor to make prospective clients and non-handicapped citizens alike, aware of available vocational rehabilitation services and of the value of a rehabilitated client to the economy and culture of the community as a whole. Improvement of the agency image should be accompanied by improvement of the image of the disabled so that business, industry, and the general public will support rehabilitation as a sound community investment.

The development of the network for information will allow the public relations program to reveal more accurately what is being done for the various categories of disabled in Ohio -- the mentally ill, the mentally retarded, the tuberculous, crippled children, the public offender, the economically deprived, the blind, the aging, the deaf and hard of hearing. Further, such a program can stimulate the growth of community planning and cooperation in making available community funds and resources for broadening the rehabilitation services available to its disabled citizens. Finally, a comprehensive public information program can do much to encourage business and industry to accept the rehabilitated job applicant on the basis of his abilities, and skills, and preparation for the job.

3. The Public

Various groups of citizens may require special public information emphases corresponding to specific interests. We have devoted attention to some of these special public education efforts elsewhere in this report.* Yet the total program must reflect the conviction that: "The public, employers, and clients, as well as legislators, are all recipients of the same image factors. Only their roles change. Neither can there really be contradictory emphases to legislators, employers, the general public, or prospective clients. They all see the same billboards, read the same newspapers, and watch the same television channels.

"Referral sources must be told what happened to the people they sent. Legislators and budget committees must be given accurate information about which disabled people have unmet needs, as well as which ones were placed, and which of these persons could be helped with additional funds or facilities. The public must learn more about what their state VR agency is able to do for them. But all of these aspects must fit together."[1]

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* Cf. "Interagency Coordination," p. 124; "Referral and Intake," p. 237; "Placement Into Employment," p. 239.

In the interrelated goals and processes that arise from the projected development of an information network and a strong ongoing public relations program, several specific objectives have been suggested by the citizens conducting the two-year study.

4. General Thrust of Planning Toward Public Relations

The overall expression of the views of citizens involved in the study was first recorded in the Study's Eighteen-Month Report, and bears repeating here. Its basic suppositions are still valid; moreover, it provides the framework within which further specific study recommendations were made in more recent reports.

Rehabilitation means urban renewal to most people. Few understand that this concept can mean human renewal. The idea of vocational rehabilitation is even more foreign. The average person will likely confuse vocational rehabilitation with vocational education.

Implementing the Ohio two-year study on rehabilitation will require, among other necessities, a carefully planned and executed campaign of public education. We cannot expect the public to support what they do not understand.

To assure that appropriate persons become concerned with events and projects needing their attention and that their responsibilities for rehabilitation are sensed by the public, a staff of regional coordinators skilled in community organization is needed in the field. A central staff skilled in administration, rehabilitation, community organization and public relations is needed to provide direction. At least four essential groups must become involved in each community: an organized group of citizens for rehabilitation, rehabilitation-related agencies and organizations, media, and legislators.

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[1] Dishart, Vital Issues and Recommendations, pp. 33-34.

5. Specific Public Relations Objectives

The consulting firm Harbridge House, Inc., in preparing its report for the Comprehensive Statewide Planning staff in conjunction with the two-year study, made several references to specific public relations needs and objectives. Citizens conducting regional task force studies referred to this area of need often, and made specific recommendations relating to major objectives of an effective statewide public relations program.

Harbridge House Recommendations

Comments on public relations planning occurred in the Harbridge House report in three chapters; one of these chapters dealt with the broader aspects of rehabilitation in Ohio, while the other two made specific recommendations related to the Bureau of Vocational Rehabilitation and the Bureau of Services for the Blind, respectively.

In making its recommendations related to the broad needs of effective rehabilitation programming in Ohio, the Harbridge House report recognized three factors essential to the success of such programming: availability of comprehensive, accurate, and current data; community and political support for rehabilitation programs based on understanding of the objectives and advantages of the human-investment approach embodied in the rehabilitation concept; and strong public information and public relations programs, to encourage such support through dissemination of the data available.

To these specific public relations objectives, Harbridge House, Inc., made the following recommendations:

Establish a continuing comprehensive program research capability to maintain continuing analysis of program needs and gaps or deficiencies in service. This can be done through assignment of one or more program analysts to the Commissioner for Rehabilitation Services, with support as required from

Administrative Services and Program Development and Special Services.

Develop a comprehensive continuing public information program tailored to program objectives and to community support groups. The public information function should be assigned to the Commissioner of Rehabilitation Services.

Develop a coordinated public information program designed to foster increased community and political support, including:

local and regional data on program benefits, including "Return on Investment."

increased participation by state legislators and other elected officials in program affairs -- advisory committees, opening ceremonies for new units, and so forth.[1]

Speaking of public information efforts within the Bureau of Vocational Rehabilitation, the Harbridge House study concluded:

The Public Information program is wrongly located in Administrative Services. The program, which is only about a year old, has been required to operate without a charter, without an adequate budget, and without regular supervision. It is underdeveloped and underutilized, and -- in part because of its organizational location -- not generally understood by field and State Office Staff.

Public Information should be closely associated with the highest level of agency action, in order to receive the fullest access to information and to provide adequate technical advice and support.

The report recommended that BVR:

transfer the Public Information function from Administrative Services to the Office of the Director.[2]

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[1] Assessment of Agency Performance, pp. III-7; III-8.

[2] Ibid., p. IV-33.

Guidelines were also suggested for the Bureau of Services for the Blind in improving its public relations program:

> A first step would be a complete revamping of publications and involvement of the Commission for the Blind, the Chief, and the supervisors in a cohesive program. Braille brochures might increase self-referrals. The images of VR and Social Services should be clearly distinguished in promotional material. Many extra-agency contracts can be converted to public relations purposes through advance planning. For example, local medical and opthalmological consultations can be used to develop referrals as well as to obtain information.[1]

Task Force Recommendations

Recommendations from the regional task forces for public relations programming recognized these basic objectives as factors critical to the success of rehabilitation:

broad public information programs to acquaint the general public with the needs and the potentials of Ohio's disabled and disadvantaged;

public education to the services available through rehabilitation and the proven status of rehabilitation as a sound human investment that yields both human and economic returns;

public education, public information, and public relations programs directed to specific audiences;

public education efforts related to specific disability patterns and the needs imposed on the disabled and disadvantaged by specific disabilities. Such efforts must make clear the resources available to meet these needs, and at the same time must mount a strong program to remove misconceptions and prejudices that handicap the disabled by placing a stigma on broad categories of disabling conditions.

In light of these public relations objectives, the regional task forces made several specific recommendations. Some of these had reference to the geographical areas under the regional jurisdictions, or to specific cooperative public relations programs recommended for area agencies, public and private.

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[1] Assessment of Agency Performance, p. V-46.

Other recommendations struck a recurrent theme and have validity for public relations programming throughout the state. Those listed here will give reference to the Regional Task Force submitting the recommendation.

Public education and public information programs should be initiated by the federal, state, and local governments. The role of the state rehabilitation agency should be emphasized. (Region VII -- Physical Disabilities)

The Bureau of Vocational Rehabilitation staff should take leadership in creating oppertunities for communicating an understanding of its program in each of the communities it serves. This process should include an intensive program of public education geared to enhance the understanding by potential clientele of our agencies as well as the total public which supports such services. (Region VII -- Social Disabilities)

Disseminate specific information, whether by newspaper, letter, radio or television to the medical community, the paramedical community, the handicapped, business, legislative bodies, and to the general public. (Region I -- Physical Disabilities)

The professional and lay public must be better informed about the services that BVR performs. This will require the education of family physicians, social workers, nurses, teachers, and psychologists. Unions and employers should also be a target of such an educational program, and a real attempt should be made to involve them in implementation of rehabilitation services. (Region VI -- Mental Disabilities)

Public and private employers should also be "educated" to eliminate obstacles to full-time employment; private enterprise should be encouraged to consider individuals on a one-to-one basis. (Region V -- Social Disabilities)

Consideration should be given to an expanded community education program to help eliminate the ignorance and prejudice often associated with mental illness. This program would require a coordinated effort between prospective employers, physicians, professional educators, social workers, and the general public. (Region VII -- Mental Disabilities)

Education concerning the problem of alcoholics should include information for detection of the problem early in its development. Primary prevention, that is, preventing the problem from occuring, could well take place among teenagers. A strong educational program should be focused on teenagers. (Region V -- Social Disabilities)

The committee recommends that the business community, in general, be encouraged to participate in the rehabilitation of the alcoholic. The committee recommends the development of a vigorous public information program on the goals of criminal rehabilitation and appropriate attitudes in law enforcement. (Region VI -- Social Disabilities)

6. Summary and Guidelines

Public support is essential to the success of any program, but more especially is it vital to comprehensive human services programs supported in large part through public funds.

Public support is, in actual reality, community support. Thus, a public relations program engendering such support has statewide implications for rehabilitation programs, and requires impetus and coordination at the state level; but its goals can be achieved only through strong public relations programs at the community and regional levels. Ultimately, each community will decide whether rehabilitation represents to its citizens a sound human investment toward helping the disabled and disadvantaged to help themselves.

In August of 1967, the Project Director for the Ohio Comprehensive Statewide Study participated in the VRA (RSA) Seminar on Manpower Development held at the University of Oklahoma. In a Group Workshop on Agency Problems in Manpower Development, participants discussed the public relations aspects of manpower development. Discussion centered on two questions:

"How do you develop PR awareness and motivation for a specific pattern of VR services, or for a selected geographical area?"

"How do you develop intra-agency or inter-disciplinary teamwork?"

From the Seminar materials and Workshop discussions there emerged twelve guidelines toward effecting a functional public relations program. These principles, as enunciated in the Workshop proceedings, provide specific direction toward effecting community support through public relations. They are included in this report as an example of a logical, step-by-step format within which any person responsible for activating and operating a highly effective public relations program can plan activities to carry out that responsibility.

Define the geographical perimeters of his area of operation.

Identify the specific patterns that are to be emphasized, e.g., a particular facet such as in rehabilitation services for the mentally retarded.

Set up both general and specific objectives to be obtained.

Have a clear picture of the images to be developed and the changes in behavior that have to be brought about.

Compile a comprehensive body of knowledge about the private and public related agencies exerting influence in the geographical area.

Become sufficiently astute in understanding the communities involved to really know the actual power structure, the positive and negative forces; how things get done, what the obstacles are, and who does what.

Foster both formal and informal interagency cooperation agreements starting at the apex of the hierarchy to ensure effective communication and reciprocal action across interagency and interdisciplinary lines.

Spend sufficient time with other agencies to establish rapport, enhance mutual trust and understanding, and to implement the public relations program through constructive, positive, and non-critical type interactions.

Realize the limitations, as well as strong points, of the people involved with the program and design the roles to be undertaken to take these attributes into consideration.

Design the public relations program to be flexible enough to meet the day to day fluctuations and yet have an overall direction leading to the attainment of the long range goals and objectives.

Become actively involved in the community undertakings by civic leaders and groups in order to exert positive, overt influence on their activities with special emphasis on factors creating the image locally, such as news-media coverage.

Stress the importance of the influence of the larger community actions, state and federal, on the local scene by personally attending seminars, panels, and other meetings where these significant policies are being developed.[1]

C. Involvement of Business and Industry in Rehabilitation Planning and Implementation

Much recent attention has been focused on the growing investment being made by business and industry in mining human resources and in giving impetus to programs that evidence a strong sense of social responsibility among the leaders in private enterprise.

Many have called for a gradual removal of government from those areas of human service that can best be offered by private citizens. One such area revolves around the training of the unskilled, disadvantaged and economically deprived into job roles that are in demand by the labor market. The feeling has been proven in practice by many businesses and industries throughout the country -- that job skills can best be taught in the job setting and by the employing agency demanding such skills.

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[1] Ben Coffman, Joe Dusenbury, Robert Davis, and John Webb, "Summary Group III: Workshop on Agency Problems in Manpower Development" (VRA Seminar on Manpower Development, University of Oklahoma, 1967), pp. 3-4.

Moreover, there has been a steadily growing awareness among personnel directors and management executives that the worker brings to his job the complex of abilities and failings, hopes and fears, self-confidence and dissatisfactions that involve him as a total person in the total fabric of his life. The use of psychologists and counselors in personnel departments of business and industry is not new; understanding of the potentials for such use, and emphasis on the employee as a total person are, however, evolving rapidly.

Many of the recommendations made by the Task Forces throughout the state have implications for the greater involvement of leaders from business and industry in rehabilitation planning. They range from the very general to the quite specific. On one hand, they call for continuing and increased citizen involvement in rehabilitation planning; on the other, they indicate that close cooperation with the potential employer, and frequent follow-up sessions both with the employer and the client, could provide the needed understanding in specific employment situations by which the employer might assist in, and profit from, his employee's job adjustment. This latter recommendation referred specifically to the placement of rehabilitated clients suffering from stigma-related disabilities, such as mental illness, alcoholism, and public-offender status.

To business and industry, the disabled citizen plays a role both as potential employee and as a potential consumer. Conversely, the major role played by business and industry in the community is one that touches every area of community endeavor and reaches into the lives of all citizens. In outlining the vital role played by business and industry in the lives of the disabled and disadvantaged, one need not look far to find examples.

Planning and construction of buildings to accomodate the physically handicapped may be the factor that determines for a business the increased consumer support of the physically disabled in its community. Making available items to supply the special consumer needs of the handicapped may be another. The most obvious and immediate contribution that can be made by business and industry is in the area of employment, This proved to be a major concern of the task forces on manpower; and a special section of this chapter, "Categories of Service: Placement," is devoted to that consideration.

Those conducting the two-year study were fortunate to have working with them many leaders from businesses and industries throughout Ohio. Continued participation of such leaders is crucial to the successful implementation of study recommendations and to the success of rehabilitation planning in the years to come.

D. Continuation of Planning on State and Regional Levels

The Governor's Council on Vocational Rehabilitation has recommended that there be established a state-level committee, paralleled in each region, to provide continued assistance in planning and implementation. This recommendation reflected the consensus established throughout the Task Force reports and the Statewide Ad Hoc Committee meetings that planning continue, and that state and regional structures for coordinating such planning be established to provide liaison for inter-agency cooperation and to offer support and direction for the development of new planning at the county and municipal levels.

The guidelines for continued planning outlined by the various Task Forces throughout the state indicated several areas of concern: consolidation of geographic and jurisdictional planning areas; correlation of rehabilitation planning with planning in other disciplines; centralization of services within a single locus; interagency cooperative planning; regular review and evaluation.

To meet the needs of the disabled citizens seeking service, planning must take into account the resources, employment opportunities, and community characteristics of the geographical area in which the client is to be served. It must relate to planning being undertaken in related areas of service, whether they be medically, psychologically, socially, or vocationally oriented. Finally, it must be organized and coordinated to insure that comprehensive services are made available to all disabled citizens throughout the state.

Thus, continued planning for rehabilitation services will require the highest efforts toward interagency coordination and cooperative planning at state, regional, and county levels. These problems of coordination and continued planning require long-term attention, if permanent gains are to be made. Such attention can only be provided by competent, full-time staff members. It can only be comprehensive in vision and implementation if it is supported by continuing citizen participation. Both components of a successful planning effort are deemed necessary by the Statewide Ad Hoc Committees.

The relevance of adequate professional manpower must be kept in mind when considering the recommendations pertaining to continuing planning that follow. The problems of recruiting and training, as well as retaining, competent staff -- and some recommendations toward solving such problems -- are discussed in more detail later in the chapter.

1. Geographic and Jurisdictional Areas

One major problem in planning and inter-agency coordination revolves around the diversity that is found in the geographical operating districts of the multiple state agencies offering services to people. The citizens conducting the two-year study recognized that a greater uniformity in geographic areas of jurisdiction among state agencies would facilitate cooperative planning and programming.

Such uniformity would make it less likely that the client might suffer from those delays and procedural adjustments that often accompany cooperative provision of services by agencies operating on separate geographical or jurisdictional boundaries. Elimination of such delays would insure the continuum of services required to bring the client in a logical and uninterrupted manner toward the successful completion of his rehabilitation program.

This specific concern was voiced by the Ad Hoc Committee on Facilities and Workshops:

> Because of the inadequacy of present political districting for planning purposes, the Committee recommends redistricting based upon logical contiguous geographical areas. It is specifically recommended that the Appalachian area be considered as a unit. Because the arbitrary geographic delineations of planning regions do not always coincide with the needs of clients in these areas, Regional Planning

Councils should work with each other in endeavors of mutual concern to provide services for overlapping geographical areas in contiguous regions.

Task Forces in Regions III and V voiced the same concern:

that those steps which are required to bring about greater uniformity in the geographical operating districts of the multiple state agencies should be taken (Region V);

that all state administrative and planning units be subdivided into mutually coherent sections (Region III).

The validity of this concern is emphasized by findings of other planning groups in Ohio. The following paragraph and recommendation appeared in the minutes of a committee involved in Mental Retardation Planning:[1]

"Subsequent discussion focused on the different organizational patterns into which the state is divided. It was agreed that this tends to confuse rather than clarify the availability of services. A unification of zonal boundaries would lead to better communication and more efficient provision of services. Therefore, the following recommendation is approved to be submitted to the Citizens' Committee:

"That the Citizens' Committee request the Governor to consider a correlation of current subdivisions of various state programs into coinciding zones or divisions following existing county lines."

2. Correlation with Planning in Other Disciplines

A second concern voiced by task forces throughout the state is that rehabilitation planning be correlated with on-going planning in other major areas of human service.

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[1] Lynn Timmons, "Report of Subcommittee on Utilization of Personnel," Minutes of State Task Force on Manpower (Columbus: Citizens' Committee on Mental Retardation, April, 1968).

For example, rehabilitation planning should reflect support for, and cooperation with, the planning coming from the comprehensive mental health and mental retardation studies. Rehabilitation leaders should work with leaders in Comprehensive Community Mental Health Planning toward coordination and possible joint housing of services.

Such interrelated planning can minimize the development or establishement of programs of rehabilitation service that would benefit only segments of the entire disabled population. Conversely, mutual cooperative planning efforts can eliminate wasteful duplication of services already available or proposed through other planning groups.

Certainly any planning must envision facilities and personnel that will offer adequate services to the disabled in the entire region. The statewide network of services proposed by the Governor's Council in Recommendation Two outlines a long-range solution to this problem; its step-by-step, logical development can best be determined in each region, using the guidelines established by the regional task forces. One such guideline is that recommending correlation with other planning -- general health, education and welfare planning at the state, regional and local levels, as well as more specific planning for such specialized human services as those available to the economically, culturally, and socially deprived through the Office of Economic Opportunity and the Department of Housing and Urban Development.

3. Centralization of Services Within a Single Locus

Another such guideline offered by Regional Task Forces concerns the centralization of services within a single locus.

Regional reports indicate that regional centers for comprehensive rehabilitation services might well be necessary to meet the variety and complexity of the service needs that arise from the diverse nature of the planning areas. The noticeable variations within each region are due to the multi-county nature of each region, encompassing rural and small population areas as well as large urban centers. In suggesting regional rehabilitation centers, study members, taking into account the lack of wealth and resources in rural areas surrounding the more affluent and well-equipped metropolitan centers, noted the need for a more extensive role for community hospitals in regard to referral, coordination, and provision of rehabilitation services.

At the same time, task force reports show concern for those whose service needs would not warrant spending long periods of time away from the home community, or would not require the technical and highly skilled services of a specific nature that are available only at a rehabilitation complex.

To meet local needs, regional reports suggested that the development of any central rehabilitation center should provide a feeder system for outlying counties and cities, and that district offices of state rehabilitation agencies, as well as staffs of rehabilitation centers in regions, should set up mobile teams to visit rural and small population areas on a regular, clinic basis.

4. Interagency Cooperative Planning

Regional task forces emphasized the necessity for coordinated planning, suggesting that central rehabilitation complexes include a planning and coordinating body for interagency cooperation in human service, and that its program of services, as well as boundary delineations and jurisdictional units should be in harmony with the planning recommendations of local community councils in the area.

While stressing the importance of continued citizen participation in rehabilitation planning, regional reports recognized the need for full-time, paid staff to provide state-level and regional assistance to interagency planning groups within cities, counties, and regions of Ohio.

First, the state rehabilitation agency should make available to local agencies and staff the services of its professional workers, to act as consultants in the expansion of existing programs and the development of new programs.

Second, the state rehabilitation agency should encourage the development of county or regional work committees to continue the dialogue begun in the task forces and to stimulate coordinated planning in local communities. Such working committees should be composed of as many representatives as possible from the disciplines functioning in human services in the community. These persons, sensing a personal commitment to improve human services, could stimulate, and assist in mobilizing, existing resources toward more comprehensive and timely services.

Finally, ongoing planning should be insured through the development within the state rehabilitation agency of a planning structure encompassing state level planning staff and corresponding regional planning staff. State staff should coordinate planning and development of new programs, and cooperative agreements among various agencies throughout the state. Regional staff should provide a focal point for coordinating regional interagency planning toward programming regional resources to meet human needs. Where feasible, a comprehensive council on planning at the county level could provide liaison with other counties in the region and with the regional planning staff.

It has been suggested that the primary responsibilities of state rehabilitation planning staff should include consideration of, and implementation toward:

interagency coordination in planning for services;

establishment of a uniform pattern of geographcial and administrative boundaries;

integration with other planning being carried on throughout the state.

5. Regular Review and Evaluation

In the sections that follow, guidelines for planning in specific categories will be stated. Before studying them, it is well to consider the expressed concern of the task forces throughout the state that all continued planning toward implementation -- whether in its general or more specific ramifications -- should have provided in its structure a regular system of review and evaluation.

Research into planning and implementation activities should be undertaken periodically to determine what has been accomplished, what has been overlooked, what additions or changes need to be made.

It is essential that such review seek out those failures that may have occurred by absence of adequate planned services, or by inappropriateness of services that have been planned. Most importantly, such review should include intensive follow-up studies of the outcome of rehabilitation services. Review should be made of clients earlier determined not eligible or feasible to determine whether new eligibility standards might allow them to be served. Review should also be made of clients closed not rehabilitated, or closed before plan completion, so that fuller understanding may be gained on a continuing basis and those failures in the systems for delivery of services might be recognized and corrected. Any factors that would lead clients to gain less than the maximum potential assistance from rehabilitation services should be analyzed, understood, and eliminated.

Systems for feeding data into research and information systems developed in line with the Governor's Council Recommendation Three (relating to an information network for data gathering, processing, and retrieval) should include computer storage of data related to such ongoing reviews and information about new or expanding programs, changes in eligibility requirements, and causes for non-rehabilitation as they occur. The processing of data can result in a current, reliable picture of the rehabilitation program in Ohio.

Results of analysis of such data should be made available to all cooperating rehabilitation services personnel and agencies so that they may understand the total services program as it evolves, and may make similar analyses of their own programs and services with the purpose of coordination and improvement.

In an address before rehabilitation executives, Dr. C. Esco Obermann emphasized the need for self-evaluation, not of the rehabilitation program's strengths alone, but especially of its failures and weaknesses.

"This takes courage -- this self-examination and self-evaluation. But it is the kind of courage that is demanded by life in the 20th Century in a democratic society. For if we would retain the privilege to govern ourselves we must do so responsibly and in all departments of our culture -- social, scientific, economic, as well as political. We must not be afraid of questions and we must not be afraid of the answers. If we do not discipline ourselves it will be done for us."[1]

THE PROVISION OF SERVICES: MANPOWER, INTERAGENCY COORDINATION, AND FACILITIES AND WORKSHOPS

Of the six specific study areas investigated by individual task forces in each of Ohio's seven planning regions for the two-year study, three dealt with characteristics and needs of clients as they related to planning for comprehensive rehabilitation services, and three concerned areas related to the delivery of those services.

Findings and recommendations in these latter three areas are relevant to each of the categories of study relating to client needs and characteristics -- physical disabilities, mental disabilities, and social disabilities.

The study findings and recommendations pertaining to the categories of study including manpower, interagency coordination, and facilities and workshops will, therefore, be presented next, so that their implications may be borne in mind when analyzing the statements regarding specific disability categories that follow.

A. Manpower*

Recent amendments to the Federal Vocational Rehabilitation Act have broad implications for the entire program of rehabilitation services in Ohio. The potential for extension of services to the socially disabled, including the economically and culturally deprived population poses specific problems in rehabilitation manpower that must be given immediate attention in order to provide services to a potentially vast number of new kinds of clientele.

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[1] Dishart, Vital Issues and Recommendations, pp. 5-6.

* This discussion of manpower will limit itself to those findings and recommendations in the area of staffing for provision of rehabilitation services. A second major concern of the Task Forces and Statewide Ad Hoc Committee on Manpower -- the placement of disabled and disadvantaged citizens into employment -- will be discussed in Section E: Categories of Service (Placement), later in this chapter.

This projected increase in rehabilitations is expected to occur in two major areas: (1) through increasing the number of clients served in traditional areas of disability/rehabilitation services; and (2) through adding many clients in the newly recognized categories of disability, specifically, clients handicapped by social and behavorial disorders with increased focus on poverty settings.

1. Manpower Needs

The 2% portion of the population considered eligible and feasible for rehabilitation services represents those persons whom state rehabilitation agencies can reasonably expect to serve in an expanded program whose goal would represent a 6-fold increase in rehabilitations -- 24,000 annually as compared with 4,000 in 1967 -- by 1975.

Given the increase in successful rehabilitations through the Bureau of Vocational Rehabilitation in Fiscal 1968 over Fiscal 1967 (5,616 rehabilitants as compared with 3,698, or 51.9% increase) -- a projected goal of 8,000 rehabilitated clients for Fiscal 1969, with proportionate increases annually, does not make the goal of 24,000 state-agency rehabilitations by 1975 an unreasonable one.

Yet the achievement of such a goal is based on several manpower factors, including retention of rehabilitation agency staff members and, based on their broadening experience, projected increases in individual counselor productivity. Given the agency staff members in service with the Bureau in the 1968 Fiscal Year, there is every reason to believe that 8,000 rehabilitations could have been achieved in Fiscal 1969 aside from any consideration of productivity that might have accrued from adding new staff members. Unfortunately, the possibilities are more remote in light of diminishing manpower resources.

Of those counselors responsible for the 51.9% increase in rehabilitations for Fiscal 1968 over 1967, 56 have left the staff of the Bureau of Vocational Rehabilitation. As a matter of fact, since January 1, 1968, there have been 29 resignations from service, 25 from rehabilitation counseling positions and another 4 from administrative or supervisory positions. Moreover, of those who entered the agency-coordinated training program for rehabilitation counselors, 16 left the training program prior to completion.

Unpleasant as these facts are, they must certainly be taken into account when assessing the agency's potential for achieving 8,000 rehabilitations in Fiscal 1969 and continuing the progression through percentages of increase that will effect 24,000 successful closures by 1975. Although in itself the goal is not unreasonable, optimism as to its outcome may be unwarranted unless steps are taken to stem the tide of rapid turnover and the costly and time-consuming process of training replacement staff that results.

Thus, achievement of 24,000 state-agency rehabilitations by 1975 will depend upon: manpower training; manpower retention; more effective manpower utilization; and perhaps, to some extent, upon a more liberal concept of closure criteria. The dramatic increase of service projected will require not only additional manpower utilizing new types, i.e., aide coordinator, manager, but new techniques for better utilizing the skills of all staff members, e.g., the use of group techniques in addition to the traditional one-to-one counseling approach, and increased coordination in the services and staff function of all helping agencies.

2. Maximum Utilization of Present Staff Capabilities

The attempts at solution to manpower shortages must begin with efforts to draw upon the skills and knowledge of present staff, to approach maximum utilization of their fullest potential in those daily tasks that derive their sole justification and ultimate value from the services they make available to clients. As stated in another recent study:

"There is a great need for challenging, new methods of manpower utilization. Every effort must be made to secure maximum economy in the use of scarce personnel consistent with sound practice. Perhaps the greatest potential for solving the manpower problem rests in the redeployment and utilization of existing personnel...in addition to steps which must be taken to increase the overall manpower pool, bold efforts must be made to use professionals in new ways. We need...techniques that will reach more people...and skilled technicians or sub-professionals as adjunctive treatment personnel working under the guidance and support of the trained professionals."[1]

Stated in yet another way, there is a need to study what effect the use of a different model or pattern of services might have in terms of serving more clients and in gaining the maximum possible results from presently available staff. This conslusion of the Statewide Ad Hoc Committee on Manpower was based on recommendations of the Manpower Task Forces in Ohio's seven study regions, that called for increasing both quality and quantity of present staff efforts through:

realignment of assigned duties;

incentive programs;

creation of more ideal work atmosphere and personnel standards within the framework of the civil service system;

setting quality control and performance standards, by limiting or expanding an individual's caseload assignment toward a more realistic and efficient workload to increase his overall effectiveness;

"weighting" cases so that caseload measurement and performance evaluation, including production criteria related to closures, take into account some of those qualitative, less-easily measured factors relating to certain types of disability and certain models of service patterns.

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[1] George T. Harding, Sr., M.D., Chairman and Herschel W. Nisonger, Associate Chairman, Comprehensive Community Mental Health Planning in Ohio 1963-1965 (Columbus: Final Report of the Citizens' Committee, 1965), p.53.

In recommending realignment of assigned duties, study members proposed that staff specialists be assigned to certain services so that other professional staff members might more adequately perform their functions. Specifically,

increased study should be given to the possibility of providing for job placement through placement specialists within the state rehabilitation agency and through increased utilization of the services of the staff members of the Ohio State Employment Service;

study should also be given to the possibility of developing within the state rehabilitation agency, and other rehabilitation-oriented agencies, specialists in such areas as referral/intake; case evaluation and assignment; and follow-up;

non-college personnel, aides, technicians, and other supportive staff members might well be used for specialized functions to decrease the shortage of specialized manpower by freeing presently available professional staff for those duties requiring professional training and skills.

In this latter regard, study members encouraged professionals in the field to accept these ancillary staff members as qualified associates serving an integral purpose in the rehabilitation continuum of services. That such use of ancillary personnel is becoming steadily acceptable as a workable approach to better utilization of professional time is indicated in the following frank appraisal:

"Not only should increasing numbers of rehabilitation professionals be trained, but new and innovative uses of manpower should be encouraged. Hyper-professional attitudes should be minimized: rehabilitation professionals should not perform tasks which others of lesser skills can do just as well under supervision; and professional manpower should not be overtrained for the task which they will be performing. Now is certainly the time for innovative thinking and challenging of the traditions in the general field of rehabilitation manpower."[2]

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[2] Harding and Nisonger, Comprehensive Community Mental Health Planning in Ohio 1963-1965, p. 26.

The members present at the Task Force Seminar on Manpower held in Columbus in April of 1967 concurred in the growing support for making greater use of "para-professionals" in rehabilitation programs, and suggested that "older citizens, women, minority group members, persons recently discharged from military service, and individuals who are themselves rehabilitants may provide a good source of para-professional personnel."[1]

3. Manpower Recruitment, Training and Retention

In addition to needs for greater utilization of present staff, the Statewide Ad Hoc Committee on Manpower, in the light of recommendations from the regional Manpower Task Forces, turned its attention to the problems of manpower recruitment, training and retention.

At the Task Force Seminar on Manpower held in April of 1967, some preliminary recommendations were made in relation to manpower training and retention:[2]

more graduate training facilities for vocational rehabilitation counselors are needed in Ohio. The present facilities at Kent State University, Bowling Green State University, and the University of Cincinnati are not adequate to produce the vocational counselors that will be required in future programming;

salary schedules for vocational rehabilitation counselors should be increased in Ohio in order to prevent the flow of persons trained in Ohio to other states such as California and New York.

From the study conclusions evidenced in the reports of Ohio's seven regional Manpower Task forces, the Statewide Ad Hoc Committee on Manpower concluded the following with regard to manpower recruitment and training:

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[1] James E. Sandmann, Abstract of Task Force Seminar on Manpower (Columbus: Comprehensive Statewide Planning for Vocational Rehabilitation in Ohio, April, 1967).

[2] Sandmann, Abstract.

Additional professional manpower could well be recruited through general public information endeavors regarding rehabilitation opportunities for service, and through specialized programs such as career-day programs in high schools and colleges.

Although expansion of rehabilitation counselor training into other universities should be a serious consideration in future planning, the graduate training programs at Kent State University, Bowling Green University, and the University of Cincinnati offer a strong potential base for meeting manpower needs. Immediate efforts should be concentrated on strengthening these existing programs: adapting curricula and course content to provide specialized training in rehabilitation techniques appropriate to expanded concepts of disability categories and service patterns; and implementing counselor training with suitable courses in rehabilitation administration and operations of other, rehabilitation-related, state and private agencies.

a. Study of Manpower Sources -- Staff Development and Training Section -- Ohio Bureau of Vocational Rehabilitation

Since the VR program in Ohio has been expanding at a very rapid rate recently and appears to be setting a course which will require continued expansion, considerable attention needs to be given to possible sources of competent personnel to meet these needs. The Staff Development and Training Section has undertaken a survey of all colleges and universities in Ohio to determine how many people will be graduating within the next three years with training backgrounds suitable for use in rehabilitation.

(1) Survey Method

Nine occupations which have been traditionally defined as preparation for entry into rehabilitation counseling were isolated. These major fields have in common basic preparation for working with and understanding people, occupational information, and community organization.

A form was designed which was intended to solicit the number of graduates that could be expected from Ohio colleges, at the Bachelor and Master Degree levels in these nine areas, for the academic years 1967, 1968, 1969.

TABLE 2

MANPOWER POTENTIAL

	Year Expected to Graduate			Individual Areas of Study: Totals for 3 Years (cumulative)
Degree	1968	1969	1970	
A. Bachelor Degree Candidates				
Special Education	192	230	276	698
Guidance Counseling	000	000	000	000
School Psychology	000	000	000	000
Industrial Arts	101	136	151	388
Psychology	1,000	1,120	1,232	3,352
Sociology	705	808	930	2,443
Social Work	161	195	228	584
Rehabilitation Counseling	000	000	000	000
Occupational Therapy	125	25	25	75
B. Master Degree Candidates				
Special Education	125	147	197	469
Guidance Counseling	283	371	438	1,092
School Psychology	29	49	64	142
Industrial Arts	27	25	32	84
Psychology	212	245	275	732
Sociology	51	71	80	202
Social Work	144	144	144	432
Rehabilitation Counseling	16	34	61	111
Occupational Therapy	---	---	---	---

TABLE 2 (Continued)

A & B Combined Projection:	Year Expected to Graduate			Cumulative Totals
All Graduates	1968	1969	1970	All Graduates
Special Education	317	377	473	1,167
Guidance Counseling	283	371	438	1,092
School Psychology	29	49	64	142
Industrial Arts	128	161	183	472
Psychology	1,212	1,365	1,507	4,084
Sociology	756	879	1,010	2,645
Social Work	305	339	372	1,016
Rehabilitation Counseling	16	34	61	111
Occupational Therapy	25	25	25	75
C. Combined Areas of Study: Totals for Each Year				
	3,071	3,600	4,133	10,804

This form was mailed under a standard covering letter to all of the colleges and universities in the state offering at least a Bachelor's Degree program. No forms were sent to colleges offering less than a four year degree.

(2) Findings

The form was mailed to a total of fifty-four colleges and universities. Fifty-two of these schools responded. The two schools which did not respond were Youngstown University and Wilberforce University. It should be noted then that the totals are at best minimum figures.

Some of the respondents gave figures for only the 1967 year. These figures were carried unchanged for 1968 and 1969.

(3) Interpretation of Findings

The interpretation of the data included in the tables within this report are not meant to be irrefutably definitive but are included only to help the reader think in terms of forces involved in manpower supply.

Of the fifty schools responding, seven indicated that they offered no degrees in any of the nine areas listed. These seven institutions were either sectarian or technical in their orientation. You will note that in Table 2 there are no Bachelor Degree programs indicated in three areas, school psychology, guidance counseling, and rehabilitation counseling. There is no Master's Degree program in occupational therapy. In considering recruitment it would be difficult to recruit from the areas of special education, guidance counseling, school psychology and industrial arts. Most of these students are going to school summers, etc. There is an extreme shortage in the educational system for persons with these degrees which places them in great demand at relatively high salaries.

An analysis of the tables would indicate that the most fertile areas are psychology and sociology at the bachelor's level. As the figures would seem to indicate, a relatively smaller percentage continue on into graduate school than in any of the other fields. Recruitment in these areas at the

TABLE 3

MANPOWER POTENTIAL

Total Graduates - All Areas of Study

Sources	Colleges by Region	1968	1969	1970	3-Year Totals
REGION I	Bowling Green	161	211	269	641
	Defiance College	10	11	14	35
	Findlay	---	38	24	62
	Heidelberg	23	26	20	69
	Ohio Northern	31	40	42	113
	Mary Manse College	6	11	7	24
	University of Toledo	88	96	100	284
	TOTALS	319	433	476	1,228
REGION II	Baldwin Wallace	00	63	44	107
	Case Western Reserve	240	240	240	720
	Cleveland State Univ.	24	28	32	84
	Lake Erie College	27	21	24	72
	Notre Dame College	7	16	18	41
	Oberlin College	83	83	82	248
	TOTALS	381	451	440	1,272
REGION III	University of Akron	23	48	72	143
	Hiram College	19	22	24	65
	Kent State University	280	388	512	1,180
	Malone College	9	11	24	44
	Mt. Union College	18	15	26	59
	College of Wooster	45	37	52	134
	TOTALS	394	521	710	1,625
REGION IV	Ashland	40	52	65	157
	Dennison University	49	49	49	147
	Kenyon College	15	20	20	55
	Marietta College	17	14	21	52
	Muskingum College	64	68	74	206
	College of Steubenville	19	34	22	75
	TOTALS	204	237	251	692

TABLE 3 (Continued)

Sources	Colleges by Region	1968	1969	1970	3-Year Totals
	Capital University	17	20	29	66
	Ohio Dominican College	11	20	23	54
	Ohio State University	491	491	491	1,473
REGION V	Ohio University	294	345	401	1,040
	Ohio Wesleyan University	33	41	45	119
	Otterbein College	16	35	35	86
	TOTALS	862	952	1,024	2,838
	Central State Univ.	46	55	97	198
	University of Cincinnati	194	235	291	720
	College of Mt. St. Joseph	14	11	10	35
REGION VI	Western College for Women	10	25	22	57
	Wilmington College	47	30	30	107
	Xavier University	93	110	138	341
	TOTALS	420	492	670	1,582
	Antioch College	39	48	42	129
	Bluffton College	15	14	19	48
	Cedarville College	5	6	8	19
REGION VII	University of Dayton	75	107	163	345
	Miami University	200	238	263	701
	Urbana College	---	10	20	30
	Wittenberg College	35	63	70	168
	TOTALS	369	486	585	1,440

Master's Degree level, however, would be considerably more difficult because of the demand for doctoral candidates. Social work and occupational therapy would also seem to be difficult fields from which we could draw because of the demand and salary competition.

(4) Conclusions

In considering the total number of persons graduating in the next three years with the desired background (10,359), it would seem that there would be no difficulty. This argument, however, is somewhat negated because of the requirements for employment as a rehabilitation counselor. One must have a Master's Degree in Rehabilitation Counseling or a related field or a Bachelor's Degree with related casework experience equivalent to a Master's Degree.

Employment at the Bachelor Degree level from this population would have to be in a para-professional occupation such as counselor aide or as a counselor trainee. These two personnel classifications, Counselor I and Counselor II, require no related casework experience. However, these two categories cannot be used extensively unless the job specifications of rehabilitation counselors are broadly redefined.

(5) Summary

Although it appears that no single agency should have difficulty recruiting from a population of qualified individuals in excess of 10,000 the other considerations suggest to the contrary. Some of these considerations are: low salary compared to industry, few cost free fringe benefits, and the ever present strain on manpower produced by the military service. The fact that graduate study itself prevents many people from entering employment is another factor.

(6) Recommendations

A highly intensified recruiting program to search for qualified applicants should become an ongoing function of the agency.

A diversified training program which would contribute to the professional and personal growth of each individual recruited.

A program aimed at solving individual human relations problems should be instituted to retain qualified personnel.

A redefining of rehabilitation counseling permitting greater utilization of Bachelor Degree recipients should be made.

b. Evidences of Concern Outside the State Rehabilitation Agencies

Manpower recruitment, training, and retention are pressing problems among the many professional disciplines in Ohio. Other state and private service agencies are concerned with meeting these problems in relation to their more general areas of service and with regard to specific rehabilitation-related services as well.

Some excerpts from the published final report of the Citizens' Committee for Comprehensive Community Mental Health Planning in Ohio cited earlier are given here to indicate:

the general applicability and broad nature of causes relating to barriers to retention of professional staff in Ohio;

the need for innovative approaches to training in addition to college coursework, and for innovative approaches to recruitment of staff;

the concern to be found in other state agencies and professions regarding the manpower shortages in the field of rehabilitation.*

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* The statements that follow under items (1), (2), and (3), can be found in the report cited earlier on Comprehensive Community Mental Planning in Ohio 1963-1965, pp. 46-48, 60-61-66, and 70 passim.

(1) Retention of Professional Staff

First of all there is a drastic shortage in the overall numbers of professional personnel in Ohio. Ohio does not have its fair share of any one of the four major mental health professional groups.

Secondly, in addition to the documented shortage of mental health personnel in Ohio as compared with other states, there has been in recent years a marked exodus of professionals from the State system. What relationship exists between these two situations is not definite. However, in view of the natural leadership which attaches to the State mental health authority, a certain causality cannot be ruled out. The professional climate in the State as a whole may reflect, in some degree, the professional climate in the State system.

A favorable professional climate, one that will attract and retain professional personnel results from a variety of circumstances. The Citizens' Committee recognizes that salary or money is only a 'first step', and that the most difficult problems lie beyond -- in the fields of psychiatry, training, education, etc. But, unless that first step is taken, no other is possible.

The impact of salary increases provided by the 106th General Assembly is yet to be felt. In many classifications Ohio is still far behind the Federal government and many other States. The tremendous increase in programs throughout the nation is going to make competition for scarce personnel even more acute. The need for a realistic salary schedule is of fundamental importance.

(2) Innovative Approaches to Recruitment and Training

Most professional schools' training programs make no significant effort to prepare the upper middle class professional to work with the lower class client. One possible exception is the curriculum in schools of social work. But, increasingly, the prevalence of mental disorders in our society requiring urgent intervention occurs among the socially disengaged and disadvantaged. As a result, there is an urgent necessity to prepare professional persons to bridge the culture and communication gap between them and those groups needing help. One solution might be special efforts to recruit young people directly from the disadvantaged groups.

In addition to the conventional recruitment campaign, special recruitment to the professions of young people from the disadvantaged groups would seem to be a sensible utilization of manpower. Screening techniques are now available to identify intellectually capable young people as early as junior high school. By setting up a special program for counseling, advising, and supervising the academic preparation of youngsters from the most disadvantaged groups a real step could be taken toward insuring a supply of recruits for professional training in the future far more attuned to the special problems of the urban ghetto.

Due to the magnitude of the manpower problem it is well that institutions other than colleges and universities be involved in training. In-service training, workshops, joint educational programs utilizing university facilities and instructors, these and many other modes of training are being used to supplement university training, or to provide specialized training not available at universities.

(3) Shortages of Trained Professionals in Rehabilitation Counseling

Selected colleges or universities should develop or expand educational programs for vocational rehabilitation counselors, occupational therapists, and other scarce mental health and mental retardation personnel.

As community mental health centers are developed, increasing numbers of mentally ill and mentally retarded will be receiving services in their own communities. This will require many more vocational rehabilitation counselors, occupational therapists, and others. These persons, however, are in short supply in Ohio, not only because of low salaries, but particularly because of the limited educational and training resources available here.

> Vocational rehabilitation counselors are needed not only in community mental health centers and retardation facilities, but in programs for the aged, the alcoholic, and others. Ohio Mental Hygiene institutions right now need at least 25 additional specialized counselors in order to establish a minimum program of vocational rehabilitation. Yet 3 out of 4 of the 57 vocational rehabilitation counselors employed by the Bureau of Vocational Rehabilitation are not even graduates in the field.*

4. Interagency Cooperation Toward Manpower Solutions

The possibilities now being more deeply explored relative to interagency joint funding and cooperative programming for rehabilitation services have important implications for manpower needs, and suggest coordinated planning efforts toward manpower utilization through cooperative ventures among agencies via contractual, managerial, and administrative agreements.

That there is a need for better coordination among all agencies serving the disabled and disadvantaged, and all those offering the broad range of human services, is a widely accepted conclusion. The following statements appear in the Abstract of the Task Force Seminar on Manpower held April 20, 1967.

The provision of services to a vastly expanded clientele necessitates that the staff of the state rehabilitation agency will have to rely to an even greater degree on services provided by other-agency personnel. The vocational rehabilitation counselor of the future will require even greater skill in the arranging and coordinating of services for his clients.

The Bureau of Vocational Rehabilitation has certain specific legal relationships with the Bureau of Unemployment Compensation and the Veterans Administration which are, unfortunately, infrequently utilized because professional agency personnel are unaware of their existence. Steps should be taken to increase the professional worker's understanding of this legal structure.

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* Conclusion of excerpts from Comprehensive Community Mental Health Planning in Ohio 1963-1965.

In addition to the necessity for training and recruiting more professional rehabilitation workers, there is a need for the better utilization of other existing professional personnel by inculcating in them the rehabilitation point of view. Such professional groups as physicians, nurses, psychologists, and ministers can potentially make a greater contribution in the provision of rehabilitation services.

Attention should be directed at one of the most important manpower issues with regard to rehabilitation activities, i.e., professional and agency jealousy and competition. A successful community rehabilitation program requires communication and coordination among all relevant institutions and personnel.[1]

5. Specific Recommendations in the Category of Manpower[2]

a. Maximum Utilization of Present Staff Capabilities

■ That the need for greater manpower resources to provide expanded services in the field of rehabilitation be met through intensive study of alternative approaches to patterns/models of service and staff functioning.

b. Training of New Staff

■ That approaches used in staff recruitment, training, and on-going education seek to insure reinforcement of manpower in service to the disabled by increasing not only the quantity of staff available, but also the quality of individual staff performance, by providing training of all rehabilitation personnel consistent with evolving knowledge related to: the needs of the disabled; staff functions required to meet those needs.

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[1] Sandmann, Abstract.

[2] Statewide Ad Hoc Committee on Manpower, June, 1968.

c. Interagency Cooperation Toward Manpower Solutions

■ That agencies contribute to efforts to insure that present manpower be utilized to maximum efficiency and effectiveness by coordinated programming and joint efforts toward sharing more effectively among agencies those psychologists, physical therapists, and other professional specialists now available.

■ That planning and implementation toward better interagency coordination be undertaken immediately, so that through mutual understanding and common goals, agencies offering human services might better cooperate in providing those services through coordinated use of available manpower and cooperative planning of recruitment and training activities for new manpower.

B. Interagency Coordination

The advantages to be derived from interagency coordination extend beyond the values for better utilization of scarce manpower just described to cover the entire range of rehabilitation services. The real measure of the need for interagency coordination lies, ultimately, in the damage to clients that can result from fragmented services, gaps or duplication in service, time-consuming delays, jurisdictional decisions and accompanying red tape, and countless other causes for frustration and discouragement that generally occur in the absence of such coordination.

Interagency coordination seeks to reduce competition between agencies; to provide continuity of services; to identify gaps in services; and to share available information, resources, and manpower. It is accomplished through various means, among them: developing a greater degree of communication; coordination of problem-solving and planning; and cooperation in provision of services via increased compatibility of agency record-keeping systems, intensified efforts toward mutual referral processes, and intelligent understanding of agency requirements that can eliminate administrative and jurisdictional barriers to prompt and integrated delivery of services to clients.

1. Need for a Client-Centered Approach

Achieving these goals demands a willingness to put aside defensive attitudes related to professional or agency insecurities and to proceed with professional confidence across arbitrary lines of administrative and jurisdictional duty toward that fullness of professional ethics that concerns itself not with maintaining a professional or agency image but rather with providing timely and adequate service.

"There must be recognition on the part of each agency involved in the joint undertaking that it alone cannot help the individual meet all of his needs, and that inter-agency action is desirable and necessary. This means that each agency will feel a responsibility for the individual's welfare that transcends the legal or charter obligations of his organization to provide services. Another way of stating this would be to say that the agency is client centered rather than services centered. In my judgement, one of the greatest barriers to effective joint effort is found in the fact that agency personnel are often so oriented to looking at the client in terms of whether or not the agency's services will fit his needs that they make little or no effort to determine the breadth of the client's needs and to help plan a program of complete services. Changing the view point or approach of such individuals is not simple."[1]

That a speciality-oriented attitude with parochial problem-solving concepts among rehabilitation professionals is common, and that it gives rise to service patterns unfavorable to the client's progress, is indicated in the following excerpts from an article that appeared in the July, 1966 issue of Rehabilitation Literature, monthly journal of the National Society for Crippled Children and Adults.

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[1] E.B. Whitten, "Principles Underlying Effective Joint Effort" (delivered at the National Conference on Alcoholism and Vocational Rehabilitation, the University of Chicago Center for Continuing Education, January, 1965).

"With respect to community agencies and programs, the great problems are policy and eligibility limitations, the specialized fragmented character of services, the focus on conditions rather than children, the lack of any mechanism for coordination, and a gross inadequacy of interagency communication and referral.

"The features of services to the handicapped that impressed us most forcibly were their specialization and fragmentation, the lack of systematic, continuous communication and referral between health agents and agencies, and the fact that there was no agency in a position to provide a measure of coordination among the diverse agencies and services involved. There are many excellent services and programs, but in practice they seem to follow the Biblical injunction, 'Let not thy left hand know what thy right hand doeth.' Services are generally provided for specific conditions, for example, orthopedic conditions, speech problems, and rheumatic heart diseases. As a result, a child may receive excellent care for a condition for which he seeks attention but fail to have note taken of other significant coexisting conditions or to receive any overall consideration of his needs as a child.

"In other words, there was a variety of excellent programs and services for specific handicapping conditions but all too little emphasis on handicapped children as children. I am sure it is not necessary to emphasize the fact that services needed by the handicapped must be viewed broadly to include attention to other health needs and supportive social, educational, and counseling services as well as definitive treatment.

"It is natural and perhaps unavoidable that services should be first developed for specific conditions. However, if these services are not to fall tragically short of their objectives, they must embody as part of their basic philosophy the concept that a handicapped child, although he has special problems and needs growing out of one or more handicapping conditions, is first of all a child, with all the problems and needs of a normal child. If this philosophy is kept paramount, many of the detrimental results of fragmented, specialized services can be avoided. If the child, rather than a handicapping condition, is the focus of concern, each agency will provide the help it is best able to give and refer the child to as many other agencies as may be necessary to meet his total needs.

"The information and referral program that the National Society for Crippled Children and Adults is seeking to put into effect is really directed at both these facets of the problem. If it can help dispel the barrier of ignorance, fear, prejudice, and lack of motivation on the part of children and their parents,* and if it can mitigate the detrimental effects of fragmented, specialized programs, encourage a child-centered rather than condition-centered philosophy of services and stimulate more effective interagency communication and referral, it will indeed make a tremendous contribution to the cause to which we are all dedicated."[2]

2. Goals of Interagency Coordination

As intimated in the immediately preceding section, a desire to facilitate the client's progress is the factor that gives cause for review, and justifies research and planning in relation to any innovations or improvements contemplated, in the field of human services.

The well-documented existence of factors detrimental to client progress and resulting from fragmented approaches to service in the field of rehabilitation seems ample justification for placing high priority on efforts to bring about interagency coordination. Whatever the intermediate goals of such coordination, the welfare of the client, assured through appropriate, timely, and coordinated services to meet his total needs, is the primary objective.

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* Ramifications of this problem, with additional excerpts from Dr. Richardson's article, will appear in Section E of this chapter, "Specific Categories of Service," with relation to Intake and Referral under the topical heading "Education of the Potential Client to Available Rehabilitation Services."

[2] William P. Richardson, M.D., "Interagency Coordination -- A Basic Need in Serving Handicapped Children," Rehabilitation Literature, Vol. 27, No. 7, July, 1966, pp. 194-196. Copies available: Reprint AR-197; National Society for Crippled Children & Adults, 2023 West Ogden Avenue, Chicago, Illinois, .10 each.

"The welfare of the individual must be paramount in any planning of joint efforts of two or more agencies. The purpose of such joint effort must not be to avoid agency trouble, to bring about a better image of agency operations, or to humor someone who has a bright idea about agency organization and cooperation. It must be aimed at providing a continuity of care for the individual who has problems, seeking to administer services in such a way as to help the individual meet all his needs."[1]

3. Effective Communication Toward Mutual Understanding and Respect

"In our society of independent, voluntary, and public agencies, the development of comprehensive programs depends upon mutual co-operation, trust, and respect."[2] Unless communication among agencies is frank, frequent, and fruitful, there is little reason to hope for that mutual understanding that provides the atmosphere conducive to cooperative planning toward coordination of services essential to comprehensive assistance for the client.

Members of Interagency Task Forces in Ohio's seven planning regions concluded from their findings that there exists a need to:

cultivate and stimulate a spirit of cooperation among the agencies providing rehabilitation services;

provide committee opportunities for "give-and-take" relationships for both public and private agencies so that a sense of mutual cooperation, trust and respect is fostered and developed;

insure that members of the state rehabilitation agency staff collaborate with community agencies such as health and welfare departments, courts, schools, churches, business and industrial personnel departments, to identify and help people in time of crisis and stress.

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[1] Whitten, "Principles Underlying Effective Joint Effort".

[2] Rehabilitation Action Project, p. 20.

To achieve these ends, members of the study recommended periodic, planned interagency conferences; efforts on the part of each service agency to clarify for other agencies and for the general public the nature and scope of its program of services; and special efforts toward educating specific publics to the rehabilitation approach to human services.

a. Planned Interagency Dialogue

Communication is lacking between agencies dedicated to the rehabilitation of handicapped persons. If an agency does not recognize the existence, or understand the program emphases, of other agencies giving specialized human services in the area of rehabilitation, it is difficult for it to coordinate and focus its own services to the best interests of the clients who come to its doors in search of assistance.

Another distinct problem in professional communication arises from the many and complex overtones attached by different agencies and professional workers to the basic definitions of professional terms.

"There have been many misunderstandings in the rehabilitation field becuase agencies attempting to cooperate with vocational rehabilitation agencies have not clearly understood that a presumption of some degree of employability is a pre-requisite for providing vocational rehabilitation services. They have not understood what rehabilitation agencies mean by the use of such terms as eligibility and feasibility. They have been disgruntled, when state rehabilitation agencies have denied services to individuals referred under cooperative agreements. Illustrations of such misunderstandings could be given from almost any field of endeavor."[1]

Such lack of communication and confusion in concepts can lead to inappropriate planning, delays in service, duplication of effort, and lost clients. Multiplied by the number of agencies and professional staff members over the state, these problems take on proportions of such size and complexity as to warrant serious concern and immediate planning toward continuing, clear, and complete interagency communications.

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[1] Whitten, "Principles Underlying Effective Joint Effort."

So that effective communications be established and constantly maintained and reinforced among all professional rehabilitation workers in both public and private agencies -- and among these rehabilitation personnel and those professionals in related human services with whom they deal in planning a client's rehabilitation program -- some mechanism for promoting meaningful dialogue must be established.

Members of the study made the following recommendations.

There should be periodic meetings for liaison purposes at both state and regional levels among personnel of all agencies offering human services, to provide comprehensive understanding of the goals and activities of each agency; to keep staff members abreast of changing attitudes and innovations in planning and program; to maintain familiarity with agency organizational structures and to reinforce relationships among agency personnel; and to explore possibilities for furthering interagency cooperation within the framework of those legal and professional responsibilities and limitations of each individual agency.

Staff members of the state rehabilitation agency should take leadership in creating opportunities for mutual understanding of programs and services in each of the major communities in which rehabilitation agency offices or units are located.

In communities where mechanisms for dialogue already exist, through United Community Councils, local welfare councils, or similar community health and welfare federations, rehabilitation agencies and professionals should participate in them and utilize their potential for bringing about cooperative understanding to the fullest possible extent.

Providing effective opportunities for interagency consultation and communication is a necessary first step toward dispelling ignorance and misconceptions that can thwart the best intentions for cooperation at the seminal stage before these intentions are given a chance to germinate. Thus, prior to any cooperative planning toward action, "Each agency involved in the joint effort must have a clear and accurate understanding of the legal responsibilities and program objectives of the other agencies. Each organization must also understand the frame of reference in which other agencies work, the history and traditions which influence their practices, and the vocabulary that is used in the provision of services."[1]

b. Individual Agency Planning Toward Comprehensive Interagency Understanding

Since confusion exists regarding the functions of the various agencies within given communities and throughout the state, the eligibility requirements they utilize in selecting clients for service, and those cooperative referral processes by which they might implement their programs of service in conjunction with programs of service available from other agencies throughout the state, members of the study called for:

> a booklet prepared by each agency for distribution to all other agencies and interested individuals, including a written definition of that agency's function and containing a description of its eligibility requirements and its program of services.

Implementation of such a recommendation, if carried out in the context of the Governor's Council Recommendation for a Network of Information Gathering, Processing, and Retrieval, could provide a groundwork for such later comprehensive publications as: a rehabilitation agency and facility services register and reference guide to county and regional programs; a statewide comprehensive information and referral guide to agencies throughout Ohio rendering rehabilitation services.

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[1] Whitten, "Principles Underlying Effective Joint Effort."

c. Special Efforts in Public Education*

While using every resource at their command to strengthen interagency and interprofessional understanding among themselves, those in the field of rehabilitation should be actively engaged in strengthening understanding and support of the rehabilitation programs of service among those publics whose cooperation can bring mutual benefits -- implementing their own professional efforts and strengthening rehabilitation efforts -- to the ultimate benefit of clients in need of rehabilitation services.

Such special publics include: professional personnel in all medical and paramedical disciplines; administrative and therapy training staff of facilities and workshops throughout Ohio; educators and administrators in the public school systems and in all training institutions and institutions of higher learning; members of the social work professions; administrators and professional staff of state agencies administering the various public programs of social service in health, education, and welfare areas; legislators and government officials; and management and personnel staff in business and industry, including representatives of both labor and management.

Cooperation from these sources is vital to the success of rehabilitation programs. Although the public relations approach will vary from audience to audience to serve each group's special interests and needs, the general goal of all such efforts will be to enlist the cooperation of these special publics toward the success of the total rehabilitation program in meeting the needs of each client.

First, rehabilitation needs must be explained, so that professionals in these special fields will realize more fully the potentials for service in the rehabilitation approach, and the capabilities for achievement within the disabled and disadvantaged themselves that can, through rehabilitation, become contributing factors to the community.

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* See also: "Development of Community Support Through Public Education", "Involvement of Business and Industry in Rehabilitation Planning/Implementation", and "Educating the Potential Client to Available Rehabilitation Services", elsewhere in this chapter.

Education directed toward the medical and paramedical professions should be designed to encourage training in rehabilitation nursing techniques; to promote expansion of available manpower through the enlisting of paramedical personnel such as medical social workers, occupational and physical therapists, and prosthestists; to increase cooperation with the state agency rehabilitation program through regular referral of clients for those vocational, educatiional, psychiatric, psycho-social, and specialized medical services necessary in order to complement medical treatment with rehabilitation-related services that will enhance individual potential. The program of public education and public relations in this area should be mounted through professional associations, e.g., the Ohio units of the American Medical Association and the American Hospital Association, as well as through such institutions as state universities, schools of nursing and medicine, and the Ohio Department of Health.

Teachers and educators present a highly-skilled potential source of cooperation for rehabilitation professionals. They are often found to be most enthusiastic and cooperative when they are informed of the benefits that rehabilitation services can offer students. Recent emphasis in Ohio on vocational education and training has heightened the awareness of professional educators that, for some, the traditional academic approach to education is unsatisfactory. A comprehensive understanding of vocational rehabilitation services available to the economically, culturally, and socially deprived would be welcomed by educators, since these persons often form the largest base of the school-dropout population. Explanation of services available to special disability groups such as the mentally retarded, the deaf, and the blind, can reinforce the willingness of professional educators to support vocationally-oriented programs designed around the rehabilitation concept.

School psychologists and counselors should be aware of the rehabilitation services program as it related to the emotionally disturbed, the mentally ill, the slow learner, and the socially maladjusted so that they might make use of these services with students whose specialized or severe problems place them beyond the range of help immediately available through the school counseling and guidance program.

Finally, there should be an attempt to make services of the rehabilitation program comprehensible and accessible to workers in all community agencies or helping professions that deal with human needs -- ministers, welfare workers, parole officers, family services centers, child guidance clinics, and the like. "A readiness to work together, to create change where indicated, can provide new life to many people who have previsouly been set aside as waste material. The handicapped need not 'fall through the cracks.' Co-ordinated, intelligent community effort can make the difference."[1]

4. State-Level Interagency Coordination in Relation to Vocational Rehabilitation

As part of the concurrent investigation into special areas of study designed to further the effectiveness of comprehensive statewide planning for vocational rehabilitation in Ohio, the Governor's Council contracted with Greenleigh Associates, Inc., of New York/Chicago/Washington/San Francisco to study state-level interagency coordination in relation to vocational rehabilitation in the state of Ohio. Their report, published in March of 1968, contained findings in the areas of:

the position of the Bureau of Vocational Rehabilitation in State Government;

BVR and Interagency Coordination;

BVR Interagency Coordination with Specific State Agencies;

BVR and State Planning and Coordinating Agencies.

The conclusions and recommendations of Greenleigh Associates, Inc., were outlined in three sections: Introduction; Goal of Interagency Coordination; Recommendations for Coordination.

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[1] Rehabilitation Action Project, p. 22.

Some of the findings and conclusions are reproduced in this chapter. Portions of the report dealing with the methodology of the study, the legal and administrative policies contributing to interagency relationships, and detailed explanations of complex internal-management procedures -- e.g., third-party funding -- have not been included. As of this printing of the Governor's Council/Comprehensive Statewide Planning Final Report, copies of the complete Greenleigh report as published are on file with the Bureau of Vocational Rehabilitation State Office and are available for consultation by anyone wishing to explore the findings in greater detail.

a. Findings

In developing the Comprehensive Statewide Plan for Vocational Rehabilitation, the Governor's Commission is seeking to provide rehabilitation services to all eligible Ohioans by 1975. In view of the tremendous responsibility this imposes, it is unrealistic to consider one State agency as the sole means of providing these services. Only through the development of a sound system of interagency coordination, involving all State service agencies both in planning and programming, can the goal of the Governor's Commission be realized.[1]

The Position of the Bureau of Vocational Rehabilitation in State Government[2]

The State administrative structure of Ohio is composed of major divisions, designated as departments and bureaus, each headed by a director or administrator who is a cabinet-level officer and reports directly to the Governor. Within the departments there are subdivisions which are also designated as bureaus. However, these bureaus, as part of the internal structure of departments, are administratively responsible to the directors of the respective departments, in effect placing these bureaus in a secondary position in the State administrative structure.

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[1] "Transmittal Letter", Study of State-Level Interagency Coordination in Relation to Vocational Rehabilitation in the State of Ohio (New York: Greenleigh Associates, Inc., March, 1968), p.2.

[2] Greenleigh, Study, p.3.

The Bureau of Vocational Rehabilitation (BVR) is a subdivision of the State Department of Education and thus occupies a secondary position in the State administrative structure. Therefore, the Director of BVR reports directly to the Superintendent of the Department of Education. Similarly, the Bureau of Services for the Blind (BSB), which includes vocational rehabilitation services for the blind, is a subdivision of the State Department of Public Welfare and also occupies a secondary position in the State administrative structure. The Chief of BSB is administratively responsible to the State Director of Public Welfare. Although BVR and BSB are legislatively charged with program responsibilities which necessarily cross other service systems of State government, (e.g., health, welfare, manpower) which are headed by cabinet-level officers, the Director of BVR and the Chief of BSB must deal with these agency directors from their second-level positions. The ability of BVR and BSB to coordinate interagency vocational rehabilitation services is thus lessened by their relative position in the State structure.

BVR and Interagency Coordination[1]

The State Plan for the administration of the program of vocational rehabilitation in Ohio (Section 2.9) states that BVR has established and will maintain working relationships with other public and private agencies in order to assure maximum utilization and coordination of the services which all agencies in the state have to offer for the vocational rehabilitation of handicapped individuals.

The Director of BVR is responsible for interagency coordination and programming of vocational rehabilitation services for the Bureau. This responsibility includes liaison with other public and private agencies and the development of coordinated vocational rehabilitation programs with and for other public and private agencies. The Program Development and Special Services Section of BVR, under an assistant director, supports the Director in carrying out this responsibility.

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[1] Greenleigh, Study, p. 3-4.

There is evidence, as outlined below, that most BVR interagency coordination and programming efforts are in relation to specific projects and with specific institutions. To a lesser extent there is evidence of interagency coordination at top policy or administrative levels. However, if total vocational rehabilitation needs are to be met, BVR must take the initiative and assume a leadership role in statewide programming of rehabilitation services. This function should be carried out at the director's level. In addition, the Program Development and Special Services Section of BVR should increase its activities to include comprehensive vocational rehabilitation programming with other agencies while continuing to meet the need for planning specific projects, and programs.

BVR Interagency Coordination with Specific State Agencies

(1) Department of Mental Hygiene and Correction[2]

The most active interagency association of BVR has been with the Department of Mental Hygiene and Correction, a large State agency having jurisdiction over 34 institutions in the fields of mental health, mental retardation, and corrections. Of these 34 institutions, 14 have vocational rehabilitation units physically located in them: Apple Creek State Hospital, Broadview Hospital, Longview State Hospital, Cleveland Psychiatric Institute, Columbus State Hospital, Fairhill Psychiatric Institute, Dayton State Hospital, Madison Opportunity Village, Hawthornden State Hospital, Ohio State Reformatory - Men, Ohio State Reformatory - Women, Toledo State Hospital, Woodside Receiving Hospital, and Portsmouth Receiving Hospital. The superintendents of the 14 institutions individually initiated action to establish the vocational rehabilitation units, based on the needs for rehabilitation services at each institution. The superintendent of each institution, working with the state-level coordinator in the Department of Mental Hygiene and Correction, has entered into a contractual agreement with State BVR, and there are, therefore, 14 separate agreements. On the state level there is an agreement between BVR and the Department of Mental Hygiene and Correction to coordinate programs. However, this agreement does not deal with specifics. All the present contracts involve BVR third-party funding, but the initiative for action comes from the individual institutions.

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[2] Greenleigh, Study, p. 4.

If there were initial state-level action by BVR and the Department of Mental Hygiene and Correction, additional sources for third-party funding could be provided without waiting for each institution at the local level to express interest in providing vocational rehabilitation services. Through this procedure additional Federal vocational rehabilitation matching funds, presently not being utilized, could be obtained.

(2) Ohio Youth Commission[1]

The Ohio Youth Commission, responsible for institutional care of "errant children 18 and under," operates 12 training facilities throughout the state and a central evaluation center in Columbus. The Commission is involved with rehabilitation through its attempts to deal with delinquency problems and to prepare troubled Ohio youth for responsible adulthood. The state office of the Ohio Youth Commission is currently in the preliminary stages of planning with BVR at the district and local levels to set up vocational rehabilitation units in two Youth Commission institutions as pilot projects utilizing BVR third-party funds. The Youth Commission initiated action at the request of the two facilities which had indicated the need for rehabilitation services. Contact at the state level between BVR and the Youth Commission has been minimal. The sequence of involvement to date has been initially between the specific institution and local BVR, followed by action of the Youth Commission at the state level and finally BVR concurrence. No evidence of state-level BVR initial exploration was found. This is an area in which the Program Development and Special Services Section of BVR should take the lead in developing joint programming.

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[1] Greenleigh, Study, p. 5.

(3) Bureau of Workmen's Compensation[1]

The relationship of the Bureau of Workmen's Compensation with BVR is based on State legislation. Ohio law states that the Bureau of Workmen's Compensation will transfer to BVR the sum of $80,000 annually (Effective January 1, 1968) to be used for rehabilitation services for individuals industrially injured and eligible for Workmen's Compensation. (Ohio Revised Code, Section 4123.57 (D).) Through the Federal-State matching ratio of three to one for vocational rehabilitation, this results in an accrual of $240,000 in Federal funds to the State. BVR accepts referrals from the Bureau of Workmen's Compensation and uses the $80,000 annual subvention and accrued matching funds for evaluation of rehabilitation potential of industrially injured workers and offers the full range of rehabilitation services to those referrals who can benefit from these services. However, no document (contract, agreement, or memorandum of understanding) was identified in this study which delineates how the two agencies will cooperate.[2] Since the legislation does not deal with the specifics of the relationship and no document was uncovered, there apparently is a need to clearly outline a framework of operation which would serve as a guideline for interagency activity between BVR and the Bureau of Workmen's Compensation.

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[1] Greenleigh, Study, p. 5.

[2] Ibid., p. 5. Note: A written formal agreement between BVR and BWC has now been drawn up and is on file with each agency.

Workmen's Compensation referrals are made to BVR for rehabilitation services, but there is no mechanism to provide interim or final follow-up information to the Bureau of Workmen's Compensation. Follow-up reports are made to the Bureau of Workmen's Compensation if the client referred to BVR becomes dissatisfied with the efforts of BVR and voices such dissatisfaction. This points up the need for a system of referral and follow-up reporting between BVR and the Bureau of Workmen's Compensation.

(4) Bureau of Employment Services[1]

BVR, in accordance with its State Plan, has a written agreement with the Bureau of Employment Services which provides for cross-referral, information exchange, and vocational rehabilitation counselor-employment counselor cooperative working relationships. Specific interchange at present is limited to activities such as making the results of the General Aptitude Test Battery of the Bureau of Employment Services available to vocational rehabilitation counselors if they have received training in the interpretation of the test battery. With the duties of vocational rehabilitation counselors and employment counselors paralleled in the areas of vocational testing, counseling, training and placement, more extensive cooperative efforts could lead to cross-utilization of personnel in the parallel areas, adding strength to the programs of both agencies.

(5) Department of Public Welfare and Bureau of Services For the Blind[2]

The Ohio Department of Public Welfare is divided into multicounty districts each under the supervision of a State Deputy Director. Public Welfare in Ohio is administered by the counties and supervised by the State.

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[1] Greenleigh, Study, p. 6.

[2] Ibid., pp. 6-7.

Interagency activity related to rehabilitation services takes place on the local level between county welfare workers and State vocational rehabilitation counselors. Because of the dissimilarity of geographical districts between BVR and the Department of Public Welfare, meaningful interaction at the district level necessitates crossing district lines. Uniform districting by all State agencies would strengthen coordination at the state and district level.

The Bureau of Services for the Blind in the Department of Public Welfare provides rehabilitation and related services to blind residents of Ohio through five district offices and one branch office in Dayton. The full range of vocational rehabilitation services authorized by State and Federal statutes is made available to legally blind individuals residing in Ohio. In addition, related services are provided including elective or acute medical care, home teaching, children's services, home industries, and talking book service. State residence is not required, nor is eligibility for services based on financial need. There is a written agreement between BVR and BSB which is reported as satisfactory to both agencies. Major policy changes affecting both agencies are agreed upon jointly and confirmed by a written policy statement. It should be noted that the usual range of vocational rehabilitation services available to BVR clients are duplicated in BSB, except that in BSB the services are limited to clients defined as legally blind. Close and coordinated administrative ties must be maintained between BVR and BSB in view of the parallel functions of the two bureaus.

Little communication and coordination is evident at the state level between BVR, BSB and the Department of Public Welfare, even though BSB is a subdivision of the Department. The potential for coordinated activity at the state level is great, particularly with vocational rehabilitation eligibility now including the psycho-social group and public welfare serving many of the same group. In other States, agreements have been made whereby BVR counselors have been outstationed or scheduled into welfare offices to interview disabled, potentially employable welfare recipients on a regular basis. Such agreements have been worked out on the state level. Ohio has relied on local and district initiative for the development of individual relationships when state-level action could produce more comprehensive and effective coverage.

The 1967 amendments to the Social Security Act state that training opportunities and day care facilities are to be provided to potentially employable mothers in families receiving aid to families with dependent children (AFDC). The responsibility to carry out training lies with the Employment Service of the Department of Labor. Through this program a percentage of the potential trainees will be identified as needing vocational rehabilitation services. These amendments call attention to the need for sound planning on the state level between the vocational rehabilitation agency, public welfare, and the employment service, particularly with respect to cross-utilization of personnel and linkages at the local, district and state levels. To effectuate sound programming in line with the amendments, in Ohio, more active State interagency coordination must be established, specifically between BVR, the Department of Public Welfare and the Bureau of Employment Services.

(6) Department of Health[1]

BVR and Department of Health coordination in relation to vocational rehabilitation services takes place at the local level, primarily through working relationships of local public health nurses and vocational rehabilitation counselors. No evidence was found of cooperative agreements at the state level. Consideration should be given to agreements to develop program linkages between BVR and the Department of Health.

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[1] Greenleigh, Study, p. 7.

BVR and State Planning and Coordinating Agencies[1]

The Cooperative Area Manpower Planning System (CAMPS), developed by agreement of the Federal Departments of Commerce, Health, Education and Welfare, Housing and Urban Development, Labor, and the Office of Economic Opportunity, requires representation of the State agency counterparts on the State CAMPS Committee. The State CAMPS Committee attempts to interweave manpower programs, irrespective of agency, so that State manpower planning among these agencies will be coordinated and complementary rather than duplicative. The first year State Plan in Ohio has been completed, and implementation is in the initial stages. BVR is represented on the State CAMPS Committee and this state-level coordination effort should be significant to BVR in bringing vocational rehabilitation services together with the other manpower programs in Ohio.

The Department of Urban Affairs, a new department of government in Ohio, includes Urban Services, concerned with a wide range of community problems, the Office of Appalachia, which deals with 28 counties of Eastern Ohio designated as economically depressed and eligible for Federal Economic Development funds, and the Office of Opportunity, which gives technical assistance to Ohio communities in the planning and implementation of a variety of action projects, principally through the Economic Opportunity Act of 1964. In creating the Department of Urban Affairs, the Ohio Legislature charged it with the responsibility of coordinating the various departments of State government whose activities relate to the primary functions of the Department of Urban Affairs. (Ohio Revised Code, Sections 124.02, 124.03, 124.04.) Since the functions of this new department are broad in the areas of economic and human resource development, this responsibility for coordinating becomes an important factor both in the interagency relationships of BVR and in the utilization of vocational rehabilitation services as an important part of Ohio's total human resource development effort.

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[1] Greenleigh, Study, p. 7.

The State of Ohio has begun to implement Comprehensive Health Planning under P.L. 89-749 through the efforts of the Governor's Health Planning Advisory Council and the Department of Health. The Governor's Council has staff assigned to develop a comprehensive health services plan and to initiate citizen involvement in health planning. Because the concept of comprehensive health planning is so broad in its scope, it is important that BVR be involved in all phases of the health planning and take a leadership role in integrating vocational rehabilitation services into the comprehensive health plan.

b. Conclusions and Recommendations

Introduction[1]

The conclusions that have been drawn and the recommendations made are intended to serve as guidelines to strengthen state-level interagency coordination of vocational rehabilitation services in Ohio. It should be noted that the recommendations are based on the findings at the time the field work was conducted by Greenleigh Associates and that in some cases action may have already been taken by State agencies to implement certain recommendations.

With the proliferation of programs within and among a wide variety of service agencies in recent years, the necessity for interaction and coordination among agencies has become increasingly imperative. Because of the demands upon them, agencies have developed programs almost independently at a time when the broadened scope of activity -- not only in vocational rehabilitation but in health, employment, welfare, corrections and, mental hygiene -- makes the need for effective interagency coordination more essential than ever before.

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[1] Greenleigh, Study, p. 9.

Interagency coordination of rehabilitation services in Ohio requires a twofold approach. Certain specific interagency activity can be initiated by BVR in the development of program linkages on an agency to agency basis. Broader programming of rehabilitation services, however, requires commitment and participation on the part of many State agencies to create effective interagency coordination of human services. As the prinicpal service agency for vocational rehabilitation in Ohio, BVR should take the initiative and assume leadership to develop specific programming with other agencies and should participate as a full partner in the development of broader interagency programming of human services generally.

In developing the Comprehensive Statewide Plan for Vocational Rehabilitation, the Governor's Commission is seeking to: provide rehabilitation services to all eligible Ohioans by 1975. In view of the tremendous responsibility this imposes, it is unrealistic to consider one State agency as the sole means of providing these services. Only through the development of a sound system of interagency coordination, involving all State service agencies both in planning and programming, can the goal of the Governor's Commission be realized.

The following recommendations are made to provide the framework for interagency coordination and to provide specific suggestions on how coordination of rehabilitation services can take place.

Goals of Interagency Coordination[1]

The primary goals of interagency coordination are (1) to provide more comprehensive services through broader interagency programming; and (2) to help assure that services are of high quality; oriented to the characteristics, requirements, and needs of the clients; and flexible and adaptable. If these goals are to be attained the following action elements are necessary:

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[1] Greenleigh, Study, p. 10.

The exchange of information among agencies through established procedures.

The development of a system for prompt referral of applicants or clients to the appropriate agency or agencies and the development of a reporting system for the follow-up of action taken, services rendered, and current status.

Joint program planning so that complementary services can be made available concurrently or consecutively through various agencies without duplication, making maximum use of available resources.

Joint program planning to eliminate unnecessary duplication of services or gaps in service and to promote common or complementary priorities among agencies.

The exchange of information on the availability of funds within closely related agencies to make possible the maximum utilization of these resources.

The modification of policies and technical and administrative requirements within agencies which may cause unnecessary problems for other State agencies.

Recommendations for Coordination*[2]

It is recommended that consideration be given to strengthening the positions of BVR and BSB in the State administrative structure.

The positions of BVR in the Department of Education and BSB in the Department of Public Welfare place each at a disadvantage in dealing with cabinet-level departments and bureaus on matters of policy and program related to interagency coordination of rehabilitation services.

* Not necessarily listed in order of priority or Relative Importance.

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[2] Greenleigh, Study, pp. 10-14.

It is recommended that the Program Development and special Services Section of BVR take the initiative in the development of joint programming of specific projects with the Departments of Public Welfare, Health, Mental Hygiene and Correction, and others, taking advantage of recent legislation and unutilized BVR funds to strengthen and broaden existing programs and to implement new programs as the opportunities arise.

The presently existing agreements between BVR and other State agencies were made through cooperative efforts at the local level, channeled to the state level of the participating agency and finally to BVR for concurrence. Evidence of rather strong and effective working relationships and coordination attempts by BVR with other agencies at the district and local levels points up the need for BVR to work toward establishing state-level linkages which will complement the present efforts on the district and local levels. More comprehensive statewide programming with related agencies would support the efforts of local and district personnel in the delivery of rehabilitation services.

It is recommended that BVR and BSB should develop programs of information exchange with other State agencies.

These programs should include staff training on available services, on eligibility, and on methods of utilizing the services offered by BVR, BSB, and other State agencies.

It is recommended that a written agreement be made between BVR and the Bureau of Workmen's Compensation. This agreement should clearly outline an operational framework for coordination between the two agencies in providing total rehabilitation services for the industrially injured.

It is further recommended that a system of referral and follow-up reporting be developed between BVR and the Bureau of Workmen's Compensation.

It is recommended that uniform geographical districts for all State agencies be developed as a necessary step in achieving better interagency coordination of all human services, including rehabilitation services.

Since rehabilitation services play a significant role in comprehensive health planning, it is recommended that a close working relationship be developed by BVR with the Ohio Department of Health and the Governor's Health Planning Advisory Council in order to establish linkages between the vocational rehabilitation service system and overall health planning which was authorized under P.L. 89-749.

It is recommended that BVR take a more active part in the Cooperative Area Manpower Planning System (CAMPS) in Ohio since this state-level coordinating effort should be significant to BVR in bringing vocational rehabilitation services together with the other manpower programs of the State.

State-level action by BVR and the Department of Mental Hygiene and Correction is recommended to provide additional outlets for third-party funding without waiting for individual institutions at the local level to initiate vocational rehabilitation projects.

More extensive cooperative efforts are recommended between BVR and the Bureau of Employment Services to explore cross-utilization of vocational rehabilitation counselors and employment counselors in parallel areas of activity, thus adding strength to the programs of both agencies.

It is recommended that the Program Development and Special Services Section of BVR initiate action with the Ohio Youth Commission to develop vocational rehabilitation programs at Youth Commission training facilities in addition to the two projects currently in the preliminary stages of development.

Since the usual range of vocational rehabilitation services of BVR are duplicated in BSB, but limited to the legally blind, it is recommended that close and coordinated ties be maintained between BVR and BSB.

Increased communication and coordination between BVR and the Department of Public Welfare is recommended at the state level to produce more comprehensive and effective coverage and, through agreements, to strengthen the relationships existing on the local and district levels.

In accordance with the 1967 Amendments to the Social Security Act, it is recommended that sound planning and programming be undertaken between BVR, the Department of Public Welfare, and the Bureau of Employment Services to meet the training and rehabilitation needs of potentially employable welfare recipients.

It is recommended that BVR develop additional sources for third-party funding to utilize those Federal funds available to BVR that are to date unmatched by State funds.

The State of Ohio has been unable to utilize approximately $11 million of the Federal allocation for vocational rehabilitation because the State has not appropriated or otherwise provided for State or local matching funds.*

From this study, which was limited to interagency coordination related to vocational rehabilitation services, it has been observed that there is a need for a State organization at the Governor's level which would have the responsibility for interagency coordination of all human services. This is urgent in view of changes in services, new Federal programs, changing and broadened eligibility criteria, and increased emphasis on providing additional or new services in all agencies, not only vocational rehabilitation but health, employment, welfare, mental hygiene and corrections. There is no clear delineation of where the responsibilities of one agency end and those of another begin. The Model Cities Program also requires state-level interagency planning and coordination. An organization within the State governmental structure is needed to integrate the programming of the various State systems which deal with human resource development.

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* Cf. "Recommendation Six", Chapter III: Master Plan/Major Recommendations, for fuller exploration of possible funding sources, including third-party funding, and the inherent dangers as well as the latent potential in each such source. These portions of this final report incorporate and expand on funding ramifications explored briefly in sections of the Greenleigh recommendations not reproduced herein.

This organization could serve as a review body to appraise the feasibility of proposed projects and new programs in the total field of human services. It could be the central information point for the State on various Federal-State-local programs, could act as the state-level initiator for needed programs and services, could explore ways to finance them, and could make recommendations directly to the Governor.[1]

5. Coordination of Planning Toward Cooperative Programming of Services

Many of the conclusions reached independently during the two-year study by citizen-members of the Task Forces on Interagency Coordination in Ohio's seven planning regions were substantiated by the findings of the Greenleigh Associates, Inc., report as outlined above. All findings supported the need for increased interagency cooperation in the effort to increase the quality and quantity of rehabilitation services available to Ohio's disabled and disadvantaged populations.

Many existing state agencies and local community organizations are offering rehabilitative services in whole or in part, through programs not specifically identified as rehabilitation services programs. The state rehabilitation agencies are in a uniquely appropriate position to cooperate thoroughly with these agencies so that all such services can be strengthened and implemented through effective coordination.

The provision of increased services to those needing them can be achieved through joint funding and cooperative programming efforts as yet largely unexplored. As indicated earlier, legal interagency agreements already exist between the Bureau of Vocational Rehabilitation and the Bureaus of Workmen's Compensation (Industrial Commission) and Unemployment Compensation (Ohio State Employment Services); but except for fiscal cooperation and cross-referral of clients, strategic areas of direct action toward cooperative provision of services are to a large extent ignored, as a result, in part, of lack of understanding of the existing agreements among agency staff members.

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[1] Conclusion of excerpts from Greenleigh Study.

Under the federal provisions for joint funding and cooperative programming of rehabilitation services, the state rehabilitation agency must provide adequate measures of program control and fiscal audit to insure that rehabilitation services administered by cooperating agencies are delivered in compliance with federal and state rehabilitation program requirements under the Vocational Rehabilitation Act and parallel state legislation. At the same time, the state rehabilitation agency is given the authority to delegate the actual administration of such programs to the cooperating agencies providing services.

While it might appear logical that other state agencies would oppose joint funding and cooperative programming for rehabilitation services, on the grounds that the requirements related to fiscal audit and program control constitute undesirable external intervention into their areas of jurisdiction, quite the contrary is true in Ohio. In actual fact, it is these agencies and departments of state that are encouraging the state rehabilitation agency to explore with them possibilities for early implementation of provisions for such mutual cooperative programs of service. Those state fiscal authorities who have come to a clear understanding of rehabilitation in all its ramifications, and who perceive the nature of interrelationships between various rehabilitative services in other state agencies, have expressed interest in the state rehabilitation agency's potential role as a central coordinating organization to solidify gains to clients from all these programs and to enhance their effectiveness through the unique flexibility of funding operative in the state-federal rehabilitation programs.

Rather than duplicating programs, services, and agencies, such planning can eliminate overlapping, close existing gaps in service, and deploy state staff and funds in an efficient and economical manner to achieve a statewide program of effective human services.

6. Specific Recommendations: Interagency Coordination

The Statewide Ad Hoc Committee on Interagency Coordination proposed the following recommendations, which served as a base for Governor's Council action in recommending a Committee on Rehabilitation Program Planning as part of the Major Recommendations adopted at the meeting of the Governor's Council June 27, 1968.[1]

- That an administrative structure be set up at the state level to facilitate coordination of agencies and development of new programs throughout the state;

- That a regional interagency coordinating body be established in each region to provide a focal point for developing and programming regional resources into a cooperative effort toward rehabilitation;

- That a comprehensive council on planning be established at the county level to coordinate the functions of the many agencies and councils dedicated to the promotion and welfare of particular rehabilitative services, to eliminate wasteful duplication of services and functions, and to provide liaison with the regional planning body and other counties within the region;

- That a comprehensive unified plan be developed for each metropolitan or population center, and implemented by a continuing interagency-coordination body consolidating all health, welfare, and related planning efforts.

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[1] Statewide Ad Hoc Committee on Interagency Coordination, June, 1968.

C. Facilities and Workshops

At the heart of planning for adequate provision of service to the disabled is a statewide effort to provide those facilities and workshops in which such services may be made available in an orderly, comprehensive, and integrated continuum to those in need.

Planning for rehabilitation facilities, while including the component of physical construction and development or expansion of existing space designed to house services, embraces a far wider field related to all other categories of study investigated by regional Task Forces in the two-year comprehensive statewide planning effort. Such planning involves strategic deployment of manpower; interagency coordination toward comprehensive provision of services; and structuring of the services themselves — that is, planning for provision of those categories of service needed to overcome handicapping effects of disability, whether that disability be physical, mental, or social in nature.

1. Facilities and Workshops Planning: Needs, Goals, and Principles

In December, 1960, the Public Health Service and the Vocational Rehabilitation Administration (RSA) established an Ad Hoc Committee on planning of Facilities for Rehabilitation Services:

> to review, analyze, and evaluate the progress and accomplishments in the planning and development of facilities for rehabilitation services, and
>
> to develop principles and guidelines for more effective planning.

The report of that committee, published in February,1963, states the need for such planning, and enumerates the basic goals and principles for guiding areawide planning of facilities for rehabilitation services.

a. Need[1]

Public interest in the growing need for rehabilitation services and facilities is increasing. Planning is necessary to capitalize on this interest through the coordination of time, effort, and money of individuals, organizations, and agencies for maximum attainments with minimum waste.

b. Goals[2]

Goals are essential to give realistic and effective direction to planning efforts. The major goals for planning facilities for rehabilitation services are:

To establish and maintain rehabilitation services and facilities at a high level of quality.

To provide rehabilitation facilities and services for all types of needs of the physically and mentally disabled and the mentally retarded in all segments of the population in all geographical areas.

To develop and maintain coordinated rehabilitation services and facilities.

To develop and maintain rehabilitation services and facilities at a high level of maximum effective utilization.

To create an increasing awareness of the values of the rehabilitation process.

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[1] Areawide Planning of Facilities for Rehabilitation Services: Report of the Joint Committee of the Public Health Service and the Vocational Rehabilitation Administration (Participating Agency: Association of Rehabilitation Centers, Inc.) (Washington, D.C.: U.S. Government Printing Office, PHS Publication No. 930-B-2, April, 1963), p. viii.

[2] Ibid., pp. viii-ix.

c. Principles[3]

Basic principles essential to constructive action in planning facilities for rehabilitation services include:

Planning of facilities and services should be coordinated with other aspects of community development.

Rehabilitation services should be planned to meet the requirements of the rehabilitation process, thereby assuring continuity and individualization of services.

In areawide planning, a complete range and proper balance of component services of the rehabilitation process should be provided to meet the needs of the disabled.

Planning should be based on the rehabilitation needs of the disabled rather than the availability of financial support.

Rehabilitation facilities should be programmed within the limits of existing and potential resources of the planning area.

The feasibility of upgrading and expanding existing facilities and services should be determined prior to the development of new facilities and services.

Facilities should be located in more densely populated areas for ready accessibility.

Planning groups should develop procedures for research and ongoing self-evaluation as an integral part of the planning process.

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[3] Areawide Planning of Facilities for Rehabilitation Services, pp. ix-x passim. Only 8 of the 19 principles listed are repeated here, as most basic and relevant to Ohio planning in its present stages.

2. Facilities and Workshops: Definitions

As defined in the Vocational Rehabilitation Act, Public Law 89-333:*

Rehabilitation Facility

The term "rehabilitation facility" means a facility operated for the primary purpose of assisting in the rehabilitation of handicapped individuals:

a. Which provides one or more of the following types of services:

(1) Testing, fitting, or training in the use of prosthetic devices;

(2) Prevocational or conditioning therapy;

(3) Physical or occupational therapy;

(4) Adjustment training; or

(5) Evaluation or control of special disabilities; or

b. Through which is provided an integrated program of medical, psychological, social and vocational evaluation and services under competent professional supervision; provided, that the major portion of such evaluation and services is furnished within the facility and that all medical and related health services are prescribed by, or are under the formal supervision of persons licensed to practice medicine or surgery in the state.

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* As quoted in the publication of the U.S. Department of Health, Education and Welfare, Vocational Rehabilitation Administration (RSA): Standards for Rehabilitation Facilities and Sheltered Workshops (Washington, D.C.: U.S. Government Printing Office, 1967), pp. 1-2.

Workshop

"Workshop" means a place where any manufacture or handiwork is carried on, and which is operated for the primary purpose of providing gainful employment to the severely handicapped: a) as an interim step in the rehabilitation process for those who cannot be readily absorbed in the competitive labor market; or b) during such time as employment opportunities for them in the competitive labor market do not exist.

Thus, a workshop may be considered a specialized rehabilitation facility setting that focuses on the categories of service related to the "end" or "goal" of the rehabilitation process -- placement in a suitable vocational objective -- by providing interim or continuing services related to pre-placement, placement, and follow-up of the client in a gainful occupational setting, through the modality of actual provision of gainful employment.

The interrelation of planning needs, goals, and principles for rehabilitation facilities and workshops makes valid the application of those goals and principles stated for areawide planning of facilities for rehabilitation services, to concurrent planning for workshops, insofar as they apply within the more limited frame of reference inherent in the specialized nature and focus of workshops within the rehabilitation complex of services.

3. Proposed Five-Year Study: Ohio Workshops and Rehabilitation Facilities

In May of 1967, the Ohio Bureau of Vocational Rehabilitation published the First Year Project Report and Interim Plan of a proposed five-year study of Workshops and Rehabilitation Facilities in Ohio being conducted under part-sponsorship of a federal grant.

The report noted goals for the orderly development of planning toward establishment, improvement, and expansion of workshops and rehabilitation facilities, based on continuing in-depth studies of all workshops and rehabilitation facilities in Ohio and evolving utilization patterns based on study findings. The preliminary report noted that first-year study efforts had discovered existing workshops and rehabilitation facilities numbering in excess of 400 in Ohio. Many of these were either quite small and/or had programs only indirectly related to the state agency program of rehabilitation services. Through further study and review, those workshops and rehabilitation facilities that were not vocationally oriented or that had no direct relationship with the federal-state program of rehabilitation services were deleted.

The number of workshops and rehabilitation facilities included in the First Year Project Report and Interim Plan totalled 50, with the remaining known workshops and rehabilitation facilities scheduled for intensive study during subsequent years.

The findings of the Project Staff were based in large measure upon an inventory of workshops and rehabilitation facilities that determined Location; Name of Facility; Sponsorship of Program; Sponsor's Interest in Property; Disability Groups Served; Services Offered; Number of Clients Served Previous Year; VR Referrals in Previous Year; Average Daily Caseload; Daily Caseload Capacity; and Number Waiting for Services.

Complete findings may be reviewed in the published report. It is relevant to note here that the findings led to conclusions and preliminary recommendations for each planning region and for the state as a whole; that these findings emphasized the voluntary and private agency base for facility and workshop services, and underscored the relevance of community support to assurance of quantity and quality of facility and workshop services; that the guidelines recommended in each region reflected those planning principles requiring a complete range and proper balance of component services, made available through facilities located in more densely populated areas for ready accessibility, and provided through upgrading and expanding existing facilities and services prior to developing new facilities and services.[1]

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[1] Ohio Workshops and Rehabilitation Facilities: First Year Project Report and Interim Plan (Columbus: Ohio Bureau of Vocational Rehabilitation, May, 1967).

4. Comprehensive Statewide Planning: Facilities and Workshops Task Forces

Concurrently with the BVR Project Study of Ohio Workshops and Rehabilitation Facilities, Task Forces in each of the seven comprehensive statewide planning regions in Ohio mounted a parallel, cooperative effort to investigate this vital area of rehabilitation planning.

Cooperation and coordination of study efforts was mutually planned.

"Considerable emphasis was given to coordinating the Workshop and Rehabilitation Facility Plan with the Comprehensive Statewide Plan. Both Plan designs were prepared and structured at the same time and both project directors worked together in order to build in coordination relationships...Each plan has identical planning areas; each plan shares on an equal basis the time of the Regional Coordinators; and each plan supplements the other at the State level."[1]

"Coordination with the concurrent Facilities and Workshops Study has permitted the use of data already gathered by the BVR Facilities and Workshops Study group...This has made available to the Statewide Planning Task Forces studying Facilities and Workshops these data plus the personal interpretations of these men (BVR Facilities and Workshops Study Staff) who are ex-officio members of these Regional Task Forces."[2]

The availability to members of the Regional Task Forces of a substantial amount of information already compiled through the Facilities and Workshops Study Inventory, and the opportunities afforded through mutual consultation, allowed for convergence of findings and focus of efforts upon questions of mutually-agreed significance.

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[1] Ohio Workshops and Rehabilitation Facilities, pp. 9-10.

[2] Annual Progress Report Fiscal Year 1966-1967 (Columbus: Ohio Comprehensive Statewide Planning for Vocational Rehabilitation, May, 1967), p.17.

These questions derived from the goals of planning and sought to provide a base from which planning principles could be activated to make comprehensive rehabilitation services available to Ohio's disabled through utilization and planning for rehabilitation facilities and workshops. Simply stated, the questions were those posed by the comprehensive statewide planning project in its entire study:

What are the characteristics of those in need -- their number, their geographic and socio-economic location, their handicapping conditions, their disability types, their major service requirements?

What are the characteristics of existing resources to meet the need?

What additional resources are needed to provide total and adequate comprehensive services to all those in need?

5. Facilities and Workshops: Study Findings

Detailed study findings in each region are available in the individual Regional Reports under sections dealing with the reports of the Task Forces on Facilities and Workshops. Concurrent findings for each planning region arising from the Ohio Workshops and Rehabilitation Facilities Project study are summarized on pages 100-106 of the First Year Project Report and Interim Plan cited earlier.

The specific recommendations of each region evolved from that region's peculiar characteristics and unique rehabilitation needs and resource potential. The following material should be considered as an example of coordinated study findings with the understanding that specific planning variances from region to region must be the responsibility and privelege of each region in relation to its own needs and potential.

The Statewide Ad Hoc Committee on Facilities and Work-Shops that submitted the major recommendations of the comprehensive statewide study in this area used Region I as a reference point in discussing needs and planning for all regions. The recommendations given with regard to Region I are representative of the various needs cited in all seven regions in the area of planning for rehabilitation facilities and workshops.

In order to illustrate the meshing of findings and the complementary nature of conclusions and recommendations arising from the two studies, sample excerpts pertaining to Region I will be reprinted here.

a. Sample: Workshop and Rehabilitation Facility Project Findings: May, 1967

Planning Region I - The needs within the metropolitan area of Toledo are not being met. However, Toledo Goodwill Industries has submitted a project for acquisition of land and the construction of a new facility which will provide physical facilities to meet the immediate need. This project does not include additional staffing which will be necessary.

The Toledo Society for the Blind will require improvement and expansion to provide the needed speciality services for the visually handicapped. There is also a need for vocational services to the visually handicapped which should be expanded within one of the existing agencies.

The area in and around the city of Sandusky in Erie County has an urgent need for total services. Vocational Rehabilitation services of a comprehensive nature need to be developed by one or more agencies.

The area in and around the city of Tiffin has good medical rehabilitation facilities but a complete lack of vocational rehabilitation facility services. The need for development of vocational rehabilitation services is urgent and should be developed in conjunction with the existing medical rehabilitation services at Betty Jane Rehabilitation Center.

The extreme northwest section of this area needs considerable development and although there is a four-county effort to develop services for the mentally retarded, this will not meet the needs of all handicapped individuals.

With the exception of the city of Toledo, this region is generally a rural area with only a few relatively small cities. Long-range planning must consider the need for domiciliary services or a means of transporting clients from the rural areas to the existing or developed rehabilitation facilities and workshops.[1]

b. Sample: Task Force-Facility and Workshop Study Findings: March, 1968

Accumulated data point to the need for comprehensive rehabilitation services within Region I. Presently, there exist fragmented services within the counties, services also exist beyond the regional and state boundaries. However, there is no place where a handicapped individual may receive the full range of rehabilitation services from evaluation to placement.

Toledo apparently includes all necessary rehabilitation services and most transportation routes lead there. It may be the ideal location for the development of such a center. Definitions of services to be included remain nebulous. Basically, such a facility should include:

(1) Medical and Vocational Evaluation;
(2) Medical Treatment and Therapy Under Medical Supervision;
(3) Vocational Counseling;
(4) Psychometrics;
(5) Vocational Training;
(6) Personal Adjustment Counseling;
(7) Vocational Placement and Follow-Up;
(8) Training and Internship of Rehabilitation Personnel;
(9) In-Patient Facilities.

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[1] Ohio Workshops and Rehabilitation Facilities, pp. 100-101.

Such a facility, comprehensive in nature and regional in scope, could offer needed rehabilitation services to the region. It would not be a panacea, but it would be a beginning.

Total rehabilitation requires community awareness of individual problems. Without the support of a community any facility is doomed to failure. To suggest that a comprehensive rehabilitation facility be developed in Toledo presumes it will have community support. As it will serve Region I, its community becomes region wide necessitating the development and organization of the region for its success and growth.

It appears then, that it is necessary to also decentralize some of the facility's functions. Many individuals regard a comprehensive facility as a total answer rather than assuming the necessity of providing "feeder facilities" to the comprehensive facility, and "half-way houses" for the eventual return of the individual to his home.

It is therefore recommended that facilities and workshops be developed within local communities drawing upon the services of the comprehensive facility for those aspects of rehabilitation not offered within a local community. In this manner the rehabilitation coordinator in the region could assume the responsibility to move the client to the necessary rehabilitation services and integrate the client into his home community.[1]

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[1] "Task Force Report -- Facilities and Workshops", Region I Final Report (Columbus: Governor's Council on Vocational Rehabilitation, August, 1968).

6. Specific Recommendations: Facilities and Workshops[1]

The Statewide Ad Hoc Committee on Facilities and Workshops considered findings and conclusions from both the individual regional Task Forces on Facilities and Workshops, and the Workshop and Rehabilitation Facility Project Study. Its recommendations centered around the two recurrent themes receiving major statewide emphasis in both these studies: the specific need for Comprehensive Facilities and Satellite Facilities and Workshops in each region; and the general need for continuing rehabilitation facility and workshop planning on an on-going basis.

a. Facilities

■ That there be established in each region a comprehensive rehabilitation facility;

■ That its services include the following:

Medical and Vocational Evaluation;
Medical Treatment and Therapy under Medical Supervision;
Vocational Counseling;
Psychometrics;
Vocational Training;
Personal Adjustment Counseling;
Vocational Placement and Follow-up;
Training and Internship of Rehabilitation Personnel;
In-Patient Facilities; and

■ That planning for such a facility include the study of residential facilities needed for clients attending comprehensive centers, and that such residential arrangements as are necessary be provided for in planning and implementation related to comprehensive rehabilitation facilities.

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[1] Statewide Ad Hoc Committee on Facilities and Workshops, June, 1968.

- That existing facilities and workshops in each region be utilized as satellite facilities:

  To channel clients to the comprehensive facility for highly specialized and technical services; and

  To serve clients locally in those areas of service for which they are equipped and staffed; and

- That strong consideration be given to the advisability of providing a vocational rehabilitation counselor for each satellite facility and workshop.

b. Planning

- That the physical implementation of facilities/workshops task force recommendations as outlined above be paralleled by organizational implementation, through provision for a planning council in each of the seven regions;

- That the regional planning council include in its organizational structure, standing committees on finance and facilities/workshops;

- That action be taken to provide for the position of regional planning coordinator to serve as executive secretary to the regional planning council;

- That a Statewide Planning Council act in continuing capacity to provide assistance, direction, and statewide coordination of planning for vocational rehabilitation services.

DISABILITIES AFFECTING CLIENTS IN NEED OF SERVICE: PHYSICAL, MENTAL, SOCIAL

A. Physical Disabilities

The handicapping effects of physical disabilities have long been the focus of rehabilitation services. Concern for disabled veterans of World War I prompted rehabilitative legislation that was to develop into the present federal-state rehabilitation agency program. Gradually, rehabilitation came to embrace industrially-caused disability, physical disabilities resulting from other accident or injury, congenital anomalies, and, much more recently, disabilities that are mental or social in nature.

Thus, a great wealth of information and expertise has developed in relation to rehabilitation of the physically disabled. Physical medicine, physical therapy, prosthetics and orthotics have contributed significantly to the successful rehabilitation of the physically handicapped. Writings in the field of physical disabilities and related rehabilitation practices have composed the greater part of rehabilitation literature to date.

Yet significant new developments indicate that the role of rehabilitation services in relation to the physically disabled is far from defined or limited to past and present practices. Rehabilitation agencies have begun to assume some responsibility toward applicants with kidney disease who require hemodialysis as an on-going therapy. There are indications that rehabilitation professionals contemplate a role for rehabilitation services in restoration of clients receiving dramatic and innovative medical treatment such as heart transplants.

In addition to these factors, present conditions and awarenesses warrant investigation into existing rehabilitation practices related to the physically disabled.

Though rehabilitation of the physically disabled is the oldest of the rehabilitation emphases, physical disabilities are often bewildering or frightening to the general public. Indeed, rehabilitation counselors tend to consider specific disability groups -- the epileptic and those with cardiac disease, for example -- as "hard" cases to rehabilitate, either because of poor medical prognosis relative to work tolerance, or because of employer reluctance to hire persons with specific physical disabilities.

Finally, a growing awareness of the psychological and social factors that may complicate the handicapping effects of physical disability has brought a new counseling emphasis to rehabilitation of the physically disabled.

Recommendations

The Statewide Ad Hoc Committee on Physical Disabilities studied the recommendations made by the Physical Disabilities Task Force in each region, and approved their adoption for implementation in each region.

The Statewide Ad Hoc Committee also gave cognizance to the three general areas of need in improving rehabilitation services to the physically disabled: consideration of rehabilitation services relevant to new developments in medical treatment; intensive efforts toward improving rehabilitation services available to "hard" cases; and more thorough understanding of the psychological and social factors that might complicate the handicapping effects of physical disabilities.

In this report, these three areas have been used as guidelines toward statewide planning for services to the physically disabled. Regional recommendations have been included where appropriate. A fourth specific area of concern, rehabilitation of the deaf, incorporates the conclusions and recommendations of the Region I Subcommittee on the Deaf. The recommendations of this subcommittee have validity for general application to programs offering rehabilitation services to the deaf and hard of hearing throughout Ohio.

1. New Developments in Medical Treatment: Implications for Rehabilitation

At the Comprehensive Statewide Planning Workshop held in June, 1967, members of the Task Forces on Physical Disabilities expressed concern that, in view of the limited funds available for vocational rehabilitation, rehabilitation agencies continue to focus their efforts on clients who will profit most from the rehabilitation process.

"With the limited funds and staff available for vocational rehabilitation, greater attention must be given to the selection of cases which will show positive results. With the knowledge that is currently available too much effort is being directed to questionable cases. Too many failures are discouraging to everyone concerned including the client, rehabilitation counselor, doctor, referring agency and others."[1]

At the same time, federal and state regulations regarding the state rehabilitation agency program operations make legal provision for rehabilitation services to patients who can profit from newer forms of medical treatment. One example is the client with kidney disorders whose life can be sustained through use of dialysis treatments.

"Under 401.20 (b) of the Vocational Rehabilitation Regulations, persons with renal failure may be eligible for services since the condition which is fatal, if untreated, is considered to be stable or slowly progressive when proper medical services are received. If there is question concerning eligibility, such a case might be accepted for up to six months extended evaluation under 401.20 (c). An artifical kidney machine, supportive supplies, and equipment for home use might be purchased as 'other goods and services' (Section 401.1 (X) (1) (XIC) of the Regulations)."[2]

The rehabilitation profession is caught on the horns of a dilemma in making decisions regarding such specific cases. Dialysis "is an expensive treatment and methods must be found to control case work funds or this program could get out of balance at the expense of other disabilities needing rehabilitation."[3] It is certainly not the intent of rehabilitation professionals to deny service to anyone who is in need and can profit from such service. Yet staff members must weigh their responsibilities to the individual client in relation to their responsibilities for carrying out the mandate given the state-federal rehabilitation program to provide services on an equitable basis to all in need.

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[1] "Task Force on Physical Disabilities: Summary of Group Session," Comprehensive Statewide Planning Workshop (Columbus, Ohio: June 16, 1967).

[2] "Rehabilitation Service Series Number 67-29," VRA (RSA) in Medical Considerations in Selected Vocational Handicapping Disabilities, Oscar L. Coddington, M.D. (Columbus, Ohio: Bureau of Vocational Rehabilitation, 1966-67), p. 178.

[3] Coddington, Medical Considerations, p. 178.

The resolution to this problem, in policy, has taken the form of establishing what services may be provided, and to what degree. Experimental surgery cannot be supported from rehabilitation funds. Other physical restoration services involving large expense for long periods of time must be explored thoroughly in terms of the rehabilitation commitment to this aspect of the client's treatment. Using dialysis once again as an example:

"A suitable follow-up period after employment is customary prior to closure. Ordinarily, a six month follow-up is justified. A longer period would require specific justification. Lifetime support cannot be provided under present regulations." This all means that the counselor must explore, with the client, other resources to pay for dialysis. Title XIX should be thought of.[1]

In May, 1968, a written agreement was concluded between Ohio's Bureau of Vocational Rehabilitation and the Department of Public Welfare, "in order to assure maximum utilization of State services in the administration of the Medical Assistance Program under Title XIX of the Social Security Amendments of 1965."[2]

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[1] Coddington, Medical Considerations (Quote and comment, "Rehabilitation Service Series Number 67-29"), p. 179.

[2] E.J. Moriarty, Director, Bureau of Vocational Rehabilitation and Denver L. White, Director, Department of Public Welfare, An Agreement Between the Department of Education, Bureau of Vocational Rehabilitation, And Department of Public Welfare (Columbus, May 23/29, 1968), p. 1.

This cooperative agreement strengthens the possibilities of providing rehabilitation services to persons whose medical treatment cannot be assumed by the state-federal rehabilitation program under its provisions for physical restoration services* by establishing channels for liaison and interagency access. Item 4 of the agreement specifically establishes cooperative guidelines for cross-referral and joint responsibility in service on the part of the rehabilitation counselor and the welfare caseworker, as well as the relative responsibilities of the agencies toward such clients.

Professional ethics require, on the one hand, that services be given equitably to all those in need. In implementing rehabilitation planning with regard to advances in medical treatment, counselors must keep in mind the concerns expressed by members of the Physical Disabilities Task Forces as stated at the beginning of this discussion.

At the same time, observations made by the Region V Task Force on Mental Disabilities, and quoted in that section of this report dealing with "Mental Illness: Serving Greater Numbers of the Mentally Disabled," are applicable here, and need to be kept in mind by administrators and staff members alike.

"Since the performance of the Bureau of Vocational Rehabilitation counselors, as well as the performance of the State Bureau of Vocational Rehabilitation as a whole, is evaluated on the basis of the number of successful closed cases, there is a strong motivation on the part of the counselor and the agency to avoid the high risk of failure with the difficult case...This criterion of evaluation encourages counselors to select only those persons who will show the most certain and expedient success...This leads to the non-acceptance of the more difficult long-term cases, who may be as much, or more in need of the services as the short-term cases."

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* As defined in the 1968 Amendments to the Vocational Rehabilitation Act, physical restoration services, among them "corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and constitutes a substantial barrier to employment, but is of such a nature that correction or modification may reasonably be expected to eliminate or substantially reduce the handicap within a reasonable length of time" are included in the term "vocational rehabilitation services" but only "after full consideration of eligibility for any similar benefit by way of pension, compensation, and insurance" (Revision of Definitions, Sec. 11 (a) (2) (A); P.L. 90-391, Sec. 10).

The written agreement between the Bureau of Vocational Rehabilitation and the Department of Public Welfare may provide the necessary framework within which the counselor can satisfy his professional responsibilities both to an individual client in need of specialized medical treatment, and to his total caseload.

Two recommendations made by the Region II Task Force on Physical Disabilities serve to illustrate the concern of study members for persons who may be helped by new developments in medical treatment, and for those so-called "hard" cases discussed in the following section:

> Eligibility requirements should be reassessed towards making it easier for clients whose current status makes it difficult for them to receive service.
>
> Rehabilitation agencies should give greater attention to the needs of persons with chronic, progressively disabling conditions, adapting their programs as indicated so that the whole spectrum of services is made available to these disabled.

2. "Hard" Cases

In a survey of persons accepted for rehabilitation service during the period from January 1 through March 31, 1964, it was found that of all applicants processed by the 90 state vocational rehabilitation agencies during that period, the lowest acceptance rate was for persons with cardiac disease. While the highest non-acceptance rate for any other category was 49% of those referred,* 60% of the 5,652 referrals with cardiac disease were not accepted, most frequently because their "handicap was too severe."[1]

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* That is, 51% were accepted for service.

[1] Dishart, Vital Issues and Recommendations, p. 24.

In commenting upon this fact, administrators participating in the 1965 National Institutes for Rehabilitation Research felt that "many of these people were not really too severely handicapped to benefit from state VR services and might actually be employable.

"The problem is that the physician is faced with a tricky classification decision. If he classifies correctly, the counselor receiving the medical report will have indices of the severity of disability and the amount of work that is safe.

"Since error of classification would result in a patient's death, the physician adds a margin of safety in his classifications.

"It has been found that, especially with general practitioners, the less the physician's training and experience with cardiac cases, the greater his added margin of safety...Added to this is frequently very little knowledge by the physician of exactly how much and what kind of exertion certain occupations require.

"The result is that vocational rehabilitation counselors frequently get cardiac referrals with classifications that preclude acceptance...

"The recommended solution is for administrators, and their medical consultants, to develop good evaluation services for their cardiac referrals. Included should be the best available information about medically evaluated occupational requirements."[2]

In discussing counselor assignments to specialized caseloads, such as the mentally ill, epileptic, tuberculous, the report noted: "It was most significant that no agency reported the use of a counselor specialist for referred cardiac cases even though the acceptance rate for such cases is the lowest of all disability groups."[3]

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[2] Dishart, Vital Issues and Recommendations, p. 24.

[3] *Ibid.*, p. 26.

This specific example underscores a very real need in all areas of rehabilitation dealing with the physically disabled. Rehabilitation personnel must communicate rehabilitation goals and specific vocational requirements to the medical community, and must enlist their respect and cooperation in integrating rehabilitation services into the total complex of service envisioned by the medical profession for any given physical disability. This can best be done through cooperation with individual doctors in planning a rehabilitation program for a specific client, but such cooperation implies a familiarity with, and support for, rehabilitation goals and services on the part of the medical community.

The medical profession and the AMA should be apprised of the need for referrals of these patients, and informed of vocational rehabilitation facilities and services. (Region VII)

Rehabilitation medicine should be requested from the medical community. Where none is available, and where there is no understanding of the scope of rehabilitation medicine, employ outside help to stimulate awareness of the growing medical responsibilities involved. The physiatrist, or specialist in physical medicine and rehabilitation, is the only medical specialist whose training specifically encompasses the total concept of rehabilitation. Only by vocalized demands will the void be filled by attracting physicians into the field to meet increasing needs. (Region I)

3. Psychological and Social Factors

"We strongly maintain that unless the physical and mental aspects of a disabled person's nature are considered together no effective program for his rehabilitation can be developed."

Although this concern was stated by the Region III Task Force on Mental Disabilities, it is indicative of the total rehabilitation approach to disability and is reflected in a growing concern among rehabilitation professionals that clients with physical disability be given service that will meet the psychological and social needs that may accompany the handicapping effects of that disability.

The need for this total approach was the topic of an address delivered at the 11th Annual Tri-Organization Scientific and Clinical Rehabilitation Conference held in Los Angeles in July of 1967. After referring to "the introduction of corrective therapy as an integral aspect of medical rehabilitation," Dr. Margolin pointed out the need for understanding both the client and the therapist within the broad conceptual framework of social systems.[1]

Dr. Margolin explained the relevance of psychological and social factors as follows:

> When an individual becomes disabled there is a likelihood of experiencing major role and status changes. The change in the patient's picture may become quite pronounced if the therapist thinks only in terms of therapeutic goals of his speciality. Thus, teaching the paraplegic patient to ambulate successfully is not enough. Even the goal of returning the patient to employment is limited. Instead there must be concern with the total living pattern of the individual and the way dynamic needs are met through the different social systems. Otherwise, successful ambulation or return to employment loses its meaning and the individual functions simply as an automaton concerned primarily with primitive survival and self-preservation. Living off compensation or becoming a public assistance recipient would serve this purpose just as well, and in some cases, better. In the latter situation the size of family may result in getting more money than could be earned on the job.
>
> This conceptual framework, then, alerts us to the need for understanding and dealing with both psychodynamic and sociodynamic forces. Therapists are helped to make a distinction between the presenting problem and the real problem. The patient, for example, may overtly express an intense desire to learn how to ambulate successfully, but may covertly resist treatment for fear that he may have to give up his dependency status. Or, take another example, the patient may tell the rehabilitation counselor that he needs a job, when in actuality he needs help in resolving his conflicts aroused as a result of his dependency state that developed after incurring his disability.[2]

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[1] Reuben J. Margolin, Ed.D. "Impact of Social Systems Upon Rehabilitation of the Disabled," (presented at the 11th Annual Tri-Organization Scientific and Clinical Rehabilitation Conference, Los Angeles, California, July, 1967).

[2] *Ibid*.

General physicians, vocational rehabilitation counselors, and attorneys who work with cases involving industrial accidents and injuries should become familiar with the "Accident Process." Briefly the theory reveals that a physical injury at times results from a psychological process and the physical disturbance becomes a solution to the problems of the patient and he is unlikely to give up the physical illness. When chronicity supervenes, the patient seeks physicians who will not cure him and rejects others who appear capable of helping him. The physician, counselor and attorney should be alert to this pattern and discourage the syndrome both for the best interests of the patient and for the large sums of money used to perpetuate this process. (Region I Task Force on Mental Disabilities)

4. Rehabilitation of the Deaf

"Each of us is aware of the fact that communication is not only the key to intellectual comprehension but also a medium for the expression of feelings and emotions...Language is, it is seen clearly, the symbolic reservoir of the feelings, emotions, ideas, attitudes, and motives that are involved in the expression and perception of human experience and behavior...It can be concluded that the lack of language is a great obstacle to thinking itself and to psychosocial maturation. It is, however, a serious mistake to assume that the imperfect language used by a deaf person means defective mental ability.

"Because of lack of adequate communication, few deaf clients and patients are able to describe themselves or their needs adequately. How can the caseworker encourage the essential dignity and self-worth of these deaf clients? How can they be helped to develop and utilize their strengths? How can they be helped to feel like useful and adequate citizens in the community?"[1]

In seeking to answer these questions, Mr. Chough stresses two vital components of the total complex of skills and knowledge the worker with the deaf must bring to the service of his clients. The first is an understanding and appreciation of the general problems of the deaf; the second is the ability to communicate

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[1] Steven K. Chough, "Casework with the Deaf: A Problem in Communication," Social Work (Vol. 9, No. 4, October, 1964), pp. 77 ff.

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with the deaf by mastering the communication skills with which they are comfortable.

The Subcommittee on the Deaf, Region I, recognized both these components as vital to broad community services for the deaf, as well as to more specialized services that may be sought from the state rehabilitation agency. Its recommendations embraced needs in the fields of education, vocational training and placement, social services, mental health services, and rehabilitation services specifically ordered in a planned rehabilitation program through the state rehabilitation agency.

Education

The present grade level program for teaching the deaf should be changed to allow continuous progress through individualized instruction. This should be done not in theory but in practice. It is indicated that this will be the specific design in education of the deaf in the future.

To carry out an adequate program of education for the deaf, qualified teachers are needed. Present staff should be given whatever training is needed to allow them to meet the qualifications. In addition, newly trained teachers and work-study personnel must be recruited, and auditory equipment must be made available at both pre-school and grade and high school levels.

Authorization should be given to public day schools to teach sign language where students are unable to master oralism. The day schools and residential schools should be permitted to teach sign language where it is needed by students without forfeiture of community and state financing.

Vocational Training and Placement

A "Work Experience Program" for the deaf should be established in coordination with the high school education program.

An educational program to meet the needs of the adult deaf is needed. This would afford an excellent opportunity for the deaf to help other deaf members of the community.

Legislative review should be made for the purpose of including the deaf under the Second Injury Clause of Ohio's industrial laws.

Rehabilitation Services

Vocational rehabilitation counselors specifically assigned to the deaf should be given special consideration in caseload assignment because of the additional time involved in counseling sessions. They should be free to function with other agencies and professionals working with deaf clients, to facilitate closer coordination as, for example, with local educational facilities.

Mental Health Centers

Mental Health Centers should be planned and established to enable the deaf to receive adequate treatment. Existing mental health centers, as well as public and private agencies and hospitals should be strengthened to provide service to the deaf. This will require staff members to become acquainted with the deaf, to understand their problems, to know something of their culture, and to gain insight into their needs and weaknesses in order to offer adequate service. The staff must be capable of communicating with the deaf in the language of signs or through oralism.

Community Social Service Agencies

Community social service agencies must be equipped to offer assistance with personal and domestic problems on behalf of the deaf community. Family services should be made available to deaf citizens experiencing juvenile, marital and social problems. Staff members of such agencies must be familiar with the problems and daily habits of the deaf and must be capable of communicating with deaf persons in the community.

Agencies such as police departments, all courts, employment services, and welfare agencies should be influenced to serve the deaf adequately. Public and private agencies must be capable of offering the deaf the same standard of services given to the hearing community.

Further Recommendations

Recommendations made in Physical Disabilities Task Force Reports from Region II and Region V give additional insights into the needs that should be met in planning toward comprehensive services for the deaf community. Some of these are given below.

Organized, automatic screening of hearing and speech should be provided for all young children. (Region II)

Community social service agencies and recreational agencies should be available to persons with impaired hearing. (Region II)

No public service agency should consider itself adequately staffed unless at least one member knows the language of signs and finger spelling. (Region V)

Industrial and commerical establishments should provide for communication with the deaf in the employment office and at other strategic locations. (Region V)

A staff person in the State Department of Education should be responsible for developing and administering programs for education of deaf in the public schools. (Region V)

B. Mental Disabilities

The disability patterns commonly included in the category of mental disabilities are mental illness and mental retardation. For the purposes of the regional task force studies into mental disabilities, these two areas formed the principal base for investigation.

It should be noted here, however, that the classification "mental disability" as commonly used in RSA (VRA) disability coding practice has been estimated to include $\frac{1}{4}$, or more, of all those suffering from social disabilities. Indeed, there is a narrow margin -- useful for discussion purposes only -- between social disabilities with preponderant psychological handicapping effect, and psychological illness manifested in social maladjustment.

The distinction is an etiological one. In rehabilitation, however, the principal focus of service is upon the handicapping condition brought about by the disability. The Vocational Rehabilitation Manual gives some insight into the rehabilitation approach to disability.

In the section explaining assignment of disability codes, "Disabling Condition -- General Instructions" -- the manual states:

"The rule of thumb is this: try to make a distinction between condition and cause and use the code related to the condition. A condition would be more directly associated with the work limitation than would a cause."*

Just as many psychological or social factors may complicate the handicapping effects of physical disability, so, too, may psychological and social factors be inextricably woven together in the handicapping aspects of either mental or social disability.

Thus, it is important to consider the whole man and the ramifications of all the internal and external forces that affect him when planning for his rehabilitation. This section confines itself chiefly to rehabilitation aspects of treatment for the mentally ill and the mentally retarded; but that discussion can best be understood in the light of what has preceded and all that is to follow.

1. Definitions

The nature, scope, and range of conditions commonly labeled as "mental disability" makes definition of either mental illness or mental retardation a difficult task.

The Mental Retardation Section of the Ohio Comprehensive Mental Health Planning Project accepted the definition stated by the American Association on Mental Deficiency, which states:

Mental Retardation refers to subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior.[1]

The Mental Health Planning report states that "It is, however, difficult to formulate an all-inclusive planning definition of mental retardation because: (1) this term embraces such a wide range of manifestations resulting from a few known causes, many suspected causes which lack validity and many more unknown causes; (2) the intelligence level as determined by standard measurement instruments is not universally immutable; (3) the degree of impairment is relative to the standards of a particular culture; and (4) each person, retarded or not, must be considered as a unique individual differing in personality, in experience, in physical and social environment, in intellectual capacity and in the opportunities afforded him."[2]

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* This section, along with more detailed information on coding may be found in Appendix I, "Categories of VRA Disability Codes."

[1] Comprehensive Community Mental Health Planning, p. 193.

These latter statements have a certain validity in application to mental illness. It, too, embraces a wide range of manifestations resulting from causes that are not always well-known or well-defined. Successful treatment through controlled changes in body chemistry have indicated that biochemical, as well as psychogenetic factors, may form the base for such illness. Measured conditions causing or resulting from the illness are not immutable; moreover, reactions occur in a variety of patterns and in degrees ranging from mild (as in minor emotional disturbances) to severe (as in protracted derangement involving disorganization of the total personality.) The degree of impairment is relative to the standards of a particular culture, and each person must be considered as unique.

Psychiatric definitions of specific mental illness patterns are for the most part, descriptive rather than definitive; they delineate commonly known syndromes, and describe the illness in terms of its symptomatic reaction patterns.

For the purposes of this report, mental illness may be described as follows:

Mental Illness refers to anomalous patterns of thought or behavior typified by disordered perceptions of, or reactions to, one's self and environment, originating from psychogenetic and/or biochemical factors and often associated with impairment in adaptive behavior.

At the Task Force Seminar on Mental Disabilities held in April, 1967, participants in Comprehensive Statewide Planning for Vocational Rehabilitation in Ohio agreed upon a provisional definition of mental disability as it exists in the individual, whether that disability be mental illness or mental retardation:

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[2] Comprehensive Community Mental Health Planning, p. 193.

A mentally disabled person is anyone with a psychiatrically diagnosable illness which functionally impairs his role performances and in whom this disorder is of primary and/or of equal significance with any other major disorder.[1]

The Comprehensive Mental Health Planning report dealt with services for alcoholics and for the aging in its section devoted to "Mental Illness and Health: Rehabilitation."

In light of the task force definition of a mentally disabled person, and the distinction made in the rehabilitation disciplines between "condition" and "cause", such disabling conditions as alcoholism and those sometimes associated with the process of aging are treated in the later portion of this chapter dealing with Social Disabilities.

2. Recommendations

The two-year study of rehabilitation in Ohio, as it dealt specifically with mental disabilities, received invaluable cooperation and assistance from staff members of the Department of Mental Hygiene and Correction, as well as from citizen members of the Comprehensive Mental Health Planning Study in Ohio.

The mutual awareness of need for cooperative planning and programming evidenced by rehabilitation planners and mental health planners in this study period was implemented by planned discussion and coordination of efforts. Recommendations from both studies reflect the dialogue that has been sustained in areas of mutual concern. Carried out into the implementation of planning and continued into the development of more comprehensive programs of service, this cooperation could well serve as a model for similar joint efforts between rehabilitation staff and members of planning efforts in other areas of health, education, and community social welfare.

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[1] "Abstract of Task Force Seminar on Mental Disabilities," April, 1967.

The specific recommendations made by the Statewide Ad Hoc Committee on Mental Disabilities recognize the work already completed by the Citizens' Committee in cooperation with the Ohio Department of Mental Hygiene and Correction through the Comprehensive Mental Health Planning Project.

The recommendations call for close cooperation with the Department of Mental Hygiene and Correction, in implementing the Comprehensive Mental Health Planning recommendations in the provision of rehabilitation services to the mentally ill and mentally retarded.

At the same time, the recommendations are flexible enough to provide a base for local implementation of specific recommendations made by regional task forces in the study category of mental disabilities.

The recommendations are given here as both a summary of, and introduction to, the more specific discussion that follows.

- That rehabilitation services to the mentally disabled be coordinated with, and planned to assist in meeting the needs outlined by, Comprehensive Mental Health Planning in Ohio.

- That cooperation with the Department of Mental Hygiene and Correction continue and be expanded, so that rehabilitation services to the mentally ill and the mentally retarded include the broad range of medical, psychiatric, psycho-social, and vocational services necessary to rehabilitate these persons to the fullest human potential of which they are capable.[1]

3. Mental Retardation

In 1964, it was estimated that 4,000,000 of the total U.S. population could be defined as mentally retarded or deficient. Of that vast number, 5,993 mentally retarded persons applied for rehabilitation services to the 90 state vocational agencies during the period from January 1 through March 31, 1964. 2,337 of those applicants were not accepted for services; of the various reasons given for non-acceptance, three appeared most often.

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[1] Statewide Ad Hoc Committee on Mental Disabilities, June, 1968.

422 of the applicants not accepted "didn't respond or appear"; 431 applicants "refused services"; and in 528 cases, the reason for non-acceptance was given as "handicap too severe."[1]

These data point to two significant facts related to rehabilitation of the mentally retarded: the vast majority of mentally retarded persons are unknown to state rehabilitation agencies; of the small percentage who do apply for service, a great number are not accepted.

Both these factors must be weighed in the light of present and future efforts toward rehabilitation of the mentally retarded in Ohio.

a. Mentally Retarded Persons Not Known to State Rehabilitation Agencies

In discussing this problem, participants in the 1965 National Institutes for Rehabilitation Research gave several possible reasons for its existence.

> "Administrators felt that many of these people were adjusted within the community, even though marginally, and not recognized as people with IQ's of 69 or below. Some of these people may have other disabilities. Some may be identified with negative behavior -- such as criminal, neurotic, or alcoholism -- rather than low intelligence. Some may not be eligible or feasible for rehabilitation services. Some are served by other agencies...A starting point might be the fact that presently the major sources of referral are educational institutions which necessarily refer only young people."[2]

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[1] Dishart, Vital Issues and Recommendations, pp. 22-23.

[2] Ibid., p. 25.

One element that may be significantly related to these possible reasons for non-referral is indicated in the final report of the Citizens' Committee for Comprehensive Mental Health Planning.

Keeping in mind the fact that the larger number of referrals to rehabilitation agencies in the area of mental retardation come from educational institutions, it seems probable that the large majority of mentally retarded persons unknown to rehabilitation agencies are past the age range in which formal schooling ordinarily takes place.

As indicated by state administrators in their discussions during the 1965 National Institutes, some of these persons may be marginally adjusted within the community. Others may spend their time between the community and institutions associated with behavior other than mental retardation -- alcoholism clinics and treatment centers, correctional institutions, psychiatric clinics, etc. A great number may be institutionalized and considered permanently non-feasible for service.

Thus the relevance of this excerpt from the Citizens' Committee report on Comprehensive Mental Health Planning: "Until recent years, it was assumed that whenever a person's condition was diagnosed as mental retardation and was assigned to one of the identifying classifications (Borderline, Mild, Moderate, Severe, Profound), he would remain at this level the rest of his life. Thus, individuals were treated, trained and programmed within the limits of a static developmental level, or a single classification range. In many instances, misconceptions concerning progressive growth and development were used as reasons for not furnishing adequate community services to the mentally retarded. The intentional advancement of the individual through a series of progressive life stages was rarely considered as a principle in either planning or programming."[1]

It is no longer professionally sound to assume that those who have not contacted the state rehabilitation agency from among the mentally retarded population are probably not amenable to rehabilitation services. The need to investigate the potentials of this large number of citizens -- whether they be institutionalized or homebound in marginal community living -- is recognized by planners in both the rehabilitation field and in the area of comprehensive mental health planning.

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[1] Comprehensive Community Mental Health Planning, p. 192.

It is recognized that certain numbers of mentally retarded cannot be rehabilitated into fully independent living with placement into gainful employment in the competitive labor market. Nevertheless, a planned rehabilitation program can often prepare these individuals for community roles that embody self-care and employment in sheltered shops. Regional task force recommendations alluded to the need for such workshops, and for planned services to assist these clients into successful adaptation to their surroundings.

Terminal workshops, particularly for the mentally retarded, should be expanded in size and number, to materially increase opportunities for productive work experience for this dependent section of society. (Region III)

We must expand our training and educational facilities for the mentally retarded. Especially needed are more sheltered workshops. Since aftercare has been found to be an essential service during the most crucial period in a patient's adjustment, we need more half-way houses and day care centers. (Region VI)

A 24-hour telephone counseling service should be made available to retarded persons in the community who need advice without having to travel to a counselor's office. (Region V)

In addition to these task force recommendations, other suggestions have been made to bring the benefit of planned rehabilitation services to persons now unknown to state rehabilitation agencies.

"It was recommended that a much closer examination be given at the community level to identify possible needs of these people."[1]

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[1] Dishart, Vital Issues and Recommendations, p. 26.

> "Within Ohio there are over 9,900 mentally retarded individuals in six residential institutions...It is essentail that all institutions within the State system make the transition from purely custodial care to the preparation of as many retarded as possible for competitive employment or independent living."[1]

Rehabilitation planning must include action toward meeting the needs of this unknown majority of mentally retarded persons whether they be institutionalized or marginally adjusted to living in the community. The cooperative programming between the Bureau of Vocational Rehabilitation and the Department of Mental Hygiene and Correction has led to significant beginnings through the rehabilitation units housed in state institutions for the mentally retarded. From 1958 to 1963, "the percent of retarded rehabilitated through the Ohio Bureau of Vocational Rehabilitation has almost tripled. However, the total number of mentally retarded rehabilitated (in suitable employment at closure) in 1962-63 was 179... Clearly, new knowledge and new techniques are needed as well as additional staff and better communication with prospective employers if the retarded are to be adequately served."[2]

b. Mentally Retarded Applicants Not Accepted for Service

As indicated earlier, many of those who come to the state rehabilitation agencies seeking service are not accepted. Although reasons for non-acceptance vary, they are most often related to lack of enthusiasm on the part of the applicant, or to a judgment on the part of the agency that the applicant would not be eligible or feasible for service.

The validity of either factor as a disqualifying entity cannot be tested in the light of formerly accepted concepts or practices. Newer understandings of client motivation and recent agency flexibility allowed by the 1965 amendments to the Vocational Rehabilitation Act in the area of extended evaluation indicate the necessity of studying these two causes of non-acceptance to determine whether persons formerly disqualified under such stated reasons might not be, in fact, eligible and in need of rehabilitation services.

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[1] Comprehensive Community Mental Health Planning, p. 204.

[2] Ibid., p. 202.

Applicant Motivation

"Pertinent to successful rehabilitation is patient motivation. Encouraging appropriate patient motivation is a crucial concern for therapists. But therapists who do not understand social system dynamics may be faced with a situation where the patient resists rehabilitation planning, and the therapist is not adequately equipped to deal with such resistance. Actually, patient and therapist may be motivated to operate at cross-purposes. What constitutes primary forces in motivation is greatly dependent upon one's point of view and the surrounding social forces."[1]

In dealing with the mentally retarded, initial motivation is particularly important. If a person shows the initial interest implied by the very fact of his application for services, it is possible that his later understanding may lead him to refuse service. However, if such a decision is to be made by the applicant on the basis of his understanding of rehabilitation, it is of critical importance that this understanding be as accurate and complete as possible within his frame of reference.

Moreover, applicants who fail to "respond or appear" may need additional encouragement and repeated contact to eliminate reluctance resulting from personal feelings of inadequacy, or from fear of coping with strange people in new circumstances.

In either case, it is important to understand the mental frame of reference of the retarded applicant, and to comprehend the many possible pattern-combinations of resistance,fear, and lack of apparent motivation into which such persons may have been forced to retreat in order to cope with a world that they cannot meet on equal terms. Without such insights, counselors may tend to operate from a frame of reference and communication appropriate to other applicants, but inappropriate or even overwhelming to the retardate.

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[1] Margolin, "Impact of Social Systems Upon Rehabilitation of the Disabled."

Conversely, a counselor possessing such insights may exert special efforts in seeking out the applicant and in talking with him in language, and with attitudes, to which the applicant can respond without fear or bewilderment. By eliminating some of the potential barriers to applicant motivation, such a counselor can largely reduce the possibilities of finding the applicant uncooperative or uninterested in rehabilitation services.

Counselor Judgement of Applicant Potential

The fact that, in the study mentioned earlier, the largest single group of applicants not accepted for service were deemed not eligible or feasible for the reason "handicap too severe" leads to several considerations regarding eligibility and feasibility requirements.

First, there is a definite distinction between any given disability and the handicapping conditions that may result. For example, three individuals with the same tested intelligence quotient of 69 may have definite variations in the degree of severity of the handicapping conditions accompanying this quotient, although all three would be classified as mildly retarded.

Thus, the determination "handicap too severe" should be based on many factors, of which IQ score is an important, but not overriding consideration.

Yet there is evidence to indicate that certain IQ scores are, in and of themselves, indications to rehabilitation counselors that the client has a "handicap too severe" for rehabilitation service.

"Twenty-four state VR agencies reported a minimum acceptable IQ ranging from 35 to 70. Although counselors were generally encouraged to use their judgment, and the minimum as a guideline, such minimums nevertheless influence who is screened in as well as who is screened out. Obviously the minimum acceptable IQ will influence the number of people placed on jobs by an agency as well as the degree of handicapped people served. Adding to the inconsistency among states, in serving the mentally handicapped, is the fact that different intelligence evaluation methods are used. Some state agencies use very sensitive individual diagnostic techniques; other state agencies use coarse group tests."[1]

In the summary of recommendations relating to these issues, the following statements appear.

"State eligibility requirements, in terms of high minimum acceptable IQ's, may be screening out vocationally feasible retarded persons. Mentally retarded referrals should receive high quality individual evaluations.* Group test scores from elsewhere are usually insufficient to determine vocational feasibility.

"There are a number of advantages possible in the specialized assignment of adequately trained counselors which should be considered."[1]

Several recommendations proposed by regional task forces studying mental disabilities are relevant to this discussion of reducing non-acceptance among mentally retarded applicants.

Counselors should be trained more extensively in clinical psychology and psychiatry with the aim of encouraging them to accept for service more of the mentally disabled applicants instead of screening them out as being "problem cases." (Region V)

District offices should have one or two specialists in mental retardation on the staff to maintain a high level of professional response to problems of the retarded. The problem of caseloads should be examined for possible reduction by a sizeable proportion. The client caseload of counselors for the mentally disabled should be 1/2 or even 1/3 of the present caseload. (Region V)

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[1] Dishart, Vital Issues and Recommendations, p. 26.

* NOTE: This refers to an earlier statement, p. 25: "It was recommended that only professionally recognized diagnostic methods which evaluate the individual should be used,that IQ minimums alone are insufficient."

BVR counselors should be permanently assigned to all mental health facilities, and there should be a sufficient number of counselors so that they have reasonable caseloads. (Region VI)

These recommendations reflect a willingness within the rehabilitation agencies to use individual evaluations in dealing with mentally retarded applicants, and to avoid screening them out on the basis of IQ scores alone. They recognize also the advantages possible in specialized assignment of counselors to work with the mentally retarded. Finally, they reflect a concern that the caseload assignment allow such counselors adequate time to work intensively with the individual to build his motivation, enlist his cooperation, and discover the best means for planning toward service that will allow him to reach his maximum potential.

Possible solutions, such as "weighing cases," have been suggested to offset the negative effects of existing "closure criteria" that hamper a counselor's ability to devote adequate time and thorough counsel to each individual client.

Especially in offering service to the mentally retarded can these "caseload" and "closure" criteria weaken a counselor's effectiveness. For these very elements, adequate time and thorough counsel, may make the crucial difference between non-acceptance or lack of client motivation on the one hand, and, on the other, a successful program of rehabilitation services for the mentally retarded citizens of Ohio.

4. Mental Illness

A review of the work conducted by Comprehensive Mental Health Planning members and task force members studying mental disabilities as part of Comprehensive Statewide Planning for Vocational Rehabilitation in Ohio reveals striking similarities of concern in the area of mental illness. The Mental Disabilities Task Force Report of Region V puts these in perspective and outlines the three focal points around which rehabilitation planning needs to be based.

These focal points, or major areas of concern, are reflected in those sections of the Comprehensive Mental Health Planning final report that deal with mental illness in terms of primary prevention and treatment, as well as the section that discusses rehabilitation.

Most of the recommendations of the seven regional task force reports on mental illness revolve around one of these three needs: working from the "whole person" concept of the client; serving greater numbers of the mentally disabled; and providing assistance at the earliest possible stage of impairment.

a. Meeting the Needs of the Whole Person

"Successful rehabilitation requires that each form of treatment or other assistance brought to bear on the handicapped person be designed and evaluated in terms of the way it contributes to his most effective personally-satisfying and socially-acceptable interpersonal and occupational adjustment.

"Occupational readiness and competence are a central concern in rehabilitation efforts since the worker role frequently provides essential purpose, structure and direction to the former patient's life, as well as constituting the prime vehicle for his answering other needs of a personal, economic and social nature.

"A great many persons identified as emotionally and mentally ill have never acquired an adequate repertoire of behavior for dealing with adult responsibilities. Many such persons are to be found in public mental hospitals. They require extensive educative and socialization programs aimed at providing them with basic knowledge, attitudes, and skills for acceptable behavior of an interpersonal and vocational type. To meet their needs, hospitals must go beyond traditional treatment and incorporate new rehabilitation efforts in their programs."[1]

These are three of the five "facts and principles" stated in the Comprehensive Mental Health Planning Report as being those from which the recommendations contained in the Ohio Plan were evolved. All three indicate the concern of mental health planners for working from the "whole person" concept of the client.

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[1] Comprehensive Community Mental Health Planning, pp. 176-177.

Task force recommendations also reflect concern for incorporating the "whole person" concept into Comprehensive Statewide Planning for rehabilitation services to the mentally ill.

Rehabilitation services must be included in all comprehensive community mental health centers. This includes day hospitals and night hospitals, foster family care and half-way houses, and a wide range of work services. The mental health professions need further education on the importance of rehabilitation and techniques for carrying it out. Efforts should be made to encourage psychiatric facilities to commit themselves to rehabilitation goals. (Region VI)[2]

The present system of preparing patients for release back into the community is not adequate. A major weakness seems to lie in the communications between the clinic or hospital and the environment from which the patient came. The hospital or clinic physicians should prepare a protocol when the patient is released, and send it to the patient's family physician. Perhaps the patient's lawyer or clergyman should also be contacted. (Region I)

Since aftercare has been found to be an essential service during the most crucial period in a patient's adjustment, we need more half-way houses and day care centers. (Region VI)

Some psychiatric specialist (should) be placed at the supervisory level to assume the responsibilities of (1) screening reports for psychological disabilities, (2) encouraging the front-line vocational counselors toward greater psychological sensitivity to the total patient with multiple impairments including psychological involvement, which do not easily lend themselves as constellations of symptoms to the traditional diagnostic categories. (Region V)

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[2] Cf. Comprehensive Community Mental Health Planning, pp. 178-179.

b. Serving Greater Numbers of the Mentally Disabled

The program of the Bureau of Vocational Rehabilitation should be expanded and strengthened so that services may be provided for many more mentally ill and mentally retarded persons who, given services, can become remuneratively employed.[1]

This recommendation is the third of eight made by comprehensive mental health planners with specific reference to the rehabilitation aspects of mental illness and health.*

One approach to broadening the range of rehabilitation services so that many more of the mentally disabled may be served is to investigate the possible barriers to service that presently exist. To this end, the Region V Task Force on mental disabilities, in the section of its report dealing with mental illness, posed several questions calling for study of eligibility criteria generally used by counselors in accepting applicants for service.

"Questions such as the following are especially deserving of examination:

To what extent is the psychiatric diagnosis required for eligibility? Does the diagnosis of "schizophrenia" carry more weight than a description of intrapsychic and behavioral manifestations which may be indicative of a severe psychological problem, even though it has not been provided the medical label? Under what conditions does this hold true or not hold true? Under what specific conditions would a description so non-psychiatric as "impairment in interpersonal functioning" be sufficient to render a client eligible? Which class of referring physicians might be likely to use this terminology rather than a psychiatric diagnosis?

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[1] Comprehensive Community Mental Health Planning, p. 179.

* In addition to the eight recommendations noted here, there appear three recommendations specifically related to DMHC-BVR cooperative efforts toward rehabilitation of the mentally retarded in the report's later section on "Mental Retardation: Education, Training, and Employment" pp. 218-226.

Are middle class clients given preference in the selection process for such reasons as:

Their records are more complete, coming as they may from the better staffed private mental hospitals;

They speak the same idiom as the middle class counselor, espouse the same values, and consequently appear better able to cope with their environment. For this reason they may be judged as more "feasible".

What determines whether an applicant with an incomplete work-up will be provided the opportunity to obtain a more complete record before the evaluation is made of his eligibility and feasibility?"[2]

The Region V Task Force on Mental Disabilities recommended that research be conducted by impartial investigators from outside the Bureau of Vocational Rehabilitation into the procedures for determining eligibility for services.

The Task Force Report also noted the existence of federal provisions for a review of eligibility decisions that are not acceptable to clients, and recommended that these federal review regulations be implemented as early as possible in Region V.

In addition, the Region V Task Force Report on Mental Disabilities called attention to the problem of "closure-consciousness."

"Since the performance of the Bureau of Vocational Rehabilitation counselors, as well as the performance of the State Bureau of Vocational Rehabilitation as a whole, is evaluated on the basis of the number of successful closed cases, there is a strong motivation on the part of the counselor and the agency to avoid the high risk of failure with the difficult case and consequently, to avoid granting service to the difficult case...Here the sheer quantity of closures is seen as a potentially distorting factor in the selection of cases and in their program of treatment. This criterion of evaluation encourages counselors to select only those persons who will show the most certain and expedient success within the Bureau of Vocational Rehabilitation program, i.e., those persons who represent the short-term closures. This leads to the non-acceptance of the more difficult long-term cases, who may be as much, or more in need of the services as the short-term cases. The current evaluation system also discourages the counselor from following up on his "closures" to check whether they have continued to perform adequately on the job, or have even remained employed at all. This is time consuming and is likely to reveal the various degrees of inadequacies of the Bureau of Vocational Rehabilitation efforts provided to the client."[1]

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[2] "Meeting the Needs of Greater Numbers of the Mentally Disabled," Mental Disabilities Task Force Report, Region V.

To counteract these inadequacies, the Region V Task Force made the following recommendations:

That the Bureau of Vocational Rehabilitation take necessary steps, such as increasing staff, to become less "closure conscious";

Follow-up studies be made of participants and non-participants in the Bureau of Vocational Rehabilitation program to assess the long-term efficacy of the program.[2]

Institutional Populations

Another approach to broadening the range of rehabilitation services so that many more of the mentally disabled may be served, is to strengthen the institutional programs designed to meet the needs of patients in residence.

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[1] "Meeting the Needs of Greater Numbers of the Mentally Disabled," Mental Disabilities Task Force Report, Region V.

[2] Ibid.

One of the five "facts and principles" outlined in the Comprehensive Mental Health Planning report as forming the bases from which the recommendations contained in the Ohio Plan were evolved states:

> "All governmental departments concerned with health, welfare and education, and all private and voluntary agencies and groups with similar responsibilities should integrate vigorous rehabilitation philosophy, objectives and methods into all programs and services relating to the care, treatment or behavioral change of persons showing marked social and vocational handicaps."[1]

In line with this belief, recommendations made with regard to institutional populations include:

> That specialized full-time counselors of the Bureau of Vocational Rehabilitation be stationed in all Mental Hygiene institutions;
>
> That in-hospital rehabilitation facilities and programs be established to provide work evaluation and work adjustment training prior to discharge.[2]

Task Forces on Mental Disabilities made recommendations that also reflect a concern for those large numbers of mentally ill patients now institutionalized who are not receiving rehabilitation services.

> Vocational rehabilitation units should be located, staffed, and operated in close cooperation with all state hospitals...(Region VII)
>
> BVR counselors should be permanently assigned to all mental health facilities, and there should be a sufficient number of counselors so that they have reasonable case loads. (Region VI)

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[1] Comprehensive Community Mental Health Planning, p. 177.

[2] Ibid., p. 180.

Prior to introducing a vocational rehabilitation program to a hospital, the Bureau of Vocational Rehabilitation personnel, as well as hospital staff, should spend more time and money in preparing for the change. (Region V)

c. Providing Early Assistance

The report on Comprehensive Community Mental Health Planning divides its discussion of Mental Illness and Health into three sections: Primary Prevention; Treatment; Rehabilitation.

Both the section on primary prevention and that on treatment emphasize the need for assistance to the mentally and emotionally ill at the earliest possible stage of impairment. Much of the discussion concerning primary prevention and treatment centers on the needs of children and adolescents, for, as stated in the section on Treatment, "The early detection and prompt therapeutic management of emotional problems is usually more effective in childhood than in later years and in these beginning stages often yields quicker, less expensive, and longer lasting therapeutic and preventive results."[1]

Recommendations from Task Forces on Mental Disabilities recognize the importance of planning for services to school-age children to be included in comprehensive statewide rehabilitation planning toward meeting the needs of the mentally ill.

Screening services should be established in the public schools so that students in need of psychiatric care and subsequent rehabilitation can obtain this service as early as possible before chronicity sets in. (Region VI)

A comprehensive, enlightened, teacher-in-service program designed to assist the teacher meet the emotional needs of their respective pupils is recommended. At the university level, the curriculum for elementary and secondary teachers should include a course in abnormal psychology. The students should have the opportunity to work with the young mentally disabled at the state hospital or similar facilities. A wider availability of special education programs for the emotionally handicapped should be inaugurated. (Region I)

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[1] Comprehensive Community Mental Health Planning, p. 138.

In addition, early recognition and assistance to adults is recommended both by the Comprehensive Community Mental Health Planning report and by the Region V Task Force on Mental Disabilities. This latter report indicates the value of early identification, and suggests "high risk groups" whose members might profit from special attention.

"The disabled person should increasingly be contacted and helped prior to being identified as a "patient" in order to minimize any stigma resulting from this label or any encouragement which the traditional role of "patient" gives for dependent behavior. Early identification is also important because of the untold loss of human resources which can occur during periods of hospitalization which deplete persons of the necessary skills for community living.

"Persons in need of rehabilitation services might be identified earlier if the following high risk groups are kept under observation for possible developing disabilities:

Children who have suffered the loss of a parent due to death, divorce or separation at a crucial stage of the child's life;

Spouses and children of persons who are severely ill;

Survivors of recently deceased persons;

School failures and dropouts;

Girls who are pregnant out-of-wedlock;

Unemployed persons who have previously been regularly employed but now have been unemployed for a prolonged period of time;

Persons who have recently been required to drop in socioeconomic status;

> Persons undergoing major adaptations at critical life periods, such as: entering school; changing from a smaller school to a larger school or a distance from home; entering college and being separated from family and friends; marriage; parenthood; "loss of family" to college or marriage during the "middle years"; change from work to retirement in later years.
>
> During these particular periods of stress, illnesses have been observed to cluster and accumulate in many forms. This would justify particularly close surveillance of families and persons under these stresses."[1]

In light of these observations, the Region V Task Force recommended that:

> Representatives of the Bureau of Vocational Rehabilitation should collaborate with community agencies such as health and welfare departments, courts, schools, churches, business and industrial personnel departments, etc., to identify and help people at time of crisis and stress.[2]

5. Mental Disabilities: Context of Recommendations

The significance of any recommendations for intensified efforts in the area of rehabilitation services derives largely from the context within which such recommendations are developed and implemented.

In the area of mental disabilities, the context is perhaps best stated in the following words:

"These efforts in behalf of the mentally ill and mentally retarded can only be understood as a facet of a major new thrust

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[1] "At the Earliest Possible Stage of Impairment," Mental Disabilities Task Force Report, Region V.

[2] Ibid. Compare "Services for High Risk Situations and Groups," Comprehensive Community Mental Health Planning, pp. 113-114; pp. 124-125.

> that has as its objective the conservation of our nation's human resources. The attack is on major barriers to human fulfillment and participation in society. Poverty, discrimination, aging, and major health problems are all important areas of concern. Underpinning this attack are the financial resources of this country and a morality that stresses the importance, the dignity, the individual rights, and the potentials for spiritual and intellectual growth of all people."[1]

C. Social Disabilities

Any serious discussion of rehabilitation and social disabilities must take cognizance of the arbitrary nature of those classifications that tend to group persons on the basis of a single disabling factor. Earlier portions of this report have noted the extent of interrelation among all those elements of an individual's nature and personality that constitute the total self. The need for viewing separate elements within the total perspective is most critical when seeking to apply rehabilitation concepts to persons with social disabilities. The interplay of elements is more subtle, because the parameters of the problem include not only the client's self, but the persons and social systems constituting his environment.

Rehabilitation Legislation

The application of rehabilitation concepts and principles to social disability is relatively new. The 1965 amendments introduced the concept in these words:

"Substantial handicap to employment" means that a physical or mental disability (in the light of attendant medical, psychological, vocational, educational, cultural, social, or environmental factors) impedes an individual's occupational performance, by preventing his obtaining, retaining, or preparing for a gainful occupation consistent with his capacities and abilities."[2]

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[1] Comprehensive Community Mental Health Planning, p. 24.

[2] "Title 45: Public Welfare; Chapter IV: Vocational Rehabilitation Administration, Department of Health, Education, and Welfare; Subpart A, 401.1 (x) (1)", Federal Register, Vol. 31, No. 9 (January 14, 1966), p. 500.

In the 1968 amendments, the term "disadvantaged individuals" is defined to mean, in addition to those fitting the earlier legal definition "(i) handicapped individuals", those persons with or without an ascertained physical or mental disability who are:

"(ii) individuals disadvantaged by reason of their youth or advanced age, low educational attainments, ethnic or cultural factors, prison or delinquency records, or other conditions which constitute a barrier to employment, and (iii) other members of their families when the provision of vocational rehabilitation services to family members is necessary for the rehabilitation of an individual described in clause (i) or (ii)."[3]

Such individuals are entitled to services under the vocational evaluation and work adjustment program to be administered by state rehabilitation agencies in addition to, or apart from, the program of vocational rehabilitation services traditionally operated by these agencies. The state rehabilitation agency is thus in a position to provide such services to its own clients, and to clients of other agencies as well, and can legally provide financing of such services in cooperation with efforts of other human service agencies on the individual's behalf.

"'Evaluation and work adjustment services' include, as appropriate in each case, such services as--

(A) a preliminary diagnostic study to determine that the individual is disadvantaged, has an employment handicap, and that services are needed;

(B) a thorough diagnostic study consisting of a comprehensive evaluation of pertinent medical, psychological, vocational, educational, cultural, social, and environmental factors which bear on the individual's handicap to employment and rehabilitation potential including, to the degree needed, an evaluation of the individual's personality, intelligence level, educational achievements, work experience, vocational aptitudes and interests, personal and social adjustments, employment opportunities, and other pertinent data helpful in determining the nature and scope of services needed;

(C) services to appraise the individual's patterns of work behavior and ability to acquire occupational skills, and to develop work attitudes, work habits, work tolerance, and social and behavior patterns suitable for successful job performance, including the utilization of work, simulated or real, to assess and develop the individual's capacities to perform adequately in a work environment;

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[3] "Vocational Evaluation and Work Adjustment Program (Sec. 15 (a)," Public Law 90-391, July 7, 1968, p. 8.

(D) any other goods or services provided to a disadvantaged individual, determined (in accordance with regulations of the Secretary) to be necessary for, and which are provided for the purpose of, ascertaining the nature of the handicap to employment and whether it may reasonably be expected the individual can benefit from vocational rehabilitation services or other services available to disadvantaged individuals;

(E) outreach, referral, and advocacy; and

(F) the administration of these evaluation and work adjustment services."[1]

To cite a concrete example, a client of the welfare department could be given the services described above without loss of welfare benefits during the period of service, but with the possibility that, after service, he might be better prepared for employment and subsequent removal from the welfare rolls.

Implications For the Socially Disabled

The 1965 amendments provided for application of rehabilitation concepts to the problems of those, with physical or mental disability, handicapped by factors such as educational or cultural deprivation and an economically sub-standard environment. A great many persons handicapped by such factors have physical or behavioral disabilities that can be substantiated by medical and psychological testing. Although it is seldom difficult to establish the existence of a physical or mental disability among the greater percentage of the socially disabled, the federal mandate to rehabilitation agencies is made incontrovertibly clear with the 1968 amendments, which provide a distinct program of vocational evaluation and work adjustment services, at a federal-state funding ratio of 90:10, for persons with such handicapping factors whether or not the presence of a physical or mental disability has been established.

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[1] "Vocational Evaluation and Work Adjustment Program (Sec. 15 (a)," Public Law 90-391, July 7, 1968, p. 8.

The unequivocal charge to state agencies, then, is to extend the rehabilitation process to the critical population groups in our society, and to bring to the poor, the hopeless, and the oppressed the means to lift themselves to individual dignity, self-respect, and economic productivity.

To accomplish this, state agencies and rehabilitation professionals must bring to the challenge all that has been learned about disabilities and their handicapping effects; and must construct within this framework a viable plan of integrated services designed to meet the needs of the whole person. In the sections that follow, four categories of social disability are discussed separately; it is the intent of this report that here, as elsewhere, these discussions be weighed in the broader context of the total rehabilitation perspective.

1. The Aging

The aging, for rehabilitation purposes, are usually defined as those 45 years of age or older, because of the reluctance on the part of employers to hire persons in this age group, especially if such persons have just completed job training for a new vocational or occupational category.

Many times, the onset of physical or mental disability during the middle years makes return to former employment non-feasible; yet entry into a new occupation imposes tensions upon the disabled client both from within and from without. Again, if the work experience of a client in earlier years has been sporadic, marked by frequent or prolonged periods of unemployment, his ability to compete in the job market at 45 years of age or older is markedly reduced. Finally, even within the same occupation, changes from one employment situation to another become less acceptable in our society when they are attempted after the employee has reached age 45.

The phenomenon of aging is frequently accompanied by, and therefore characterized in terms of, certain medically diagnosable evidences of physical or mental deterioration. Yet is is not so often the deterioration process, as it is the attitude of society toward it, that constitutes the handicapping effect of aging upon the individual's potential for suitable employment. For this reason, the conditions accompanying aging are discussed in this report as constituting a type of social disability.

"The problem is an exceedingly complex one with roots in the economy, social and cultural attitudes, reality changes in the older person, and employment practices, all of which contribute to the generalized vocational loss suffered by the individual. Despite strong evidence in his favor and high work motivation, the capable older individual is compelled to accept casual, part-time, or low-level employment, if, indeed, any employment at all is available to him. At a time when he requires extensive interest, understanding, and support, he is likely to be confronted by unreasoning employers and rejecting personnel officers. The problem is exacerbated even further when the older individual possesses one or more disabilities which limit his functioning in employment.

"There is no shortage of constructive thinking about the older worker. However, most of the creative suggestions made have not yet been implemented for the benefit of aged workers as a group. Delay seems to stem from the failure of American society to actively support expanded work opportunities for older persons. Mired in ambivalent feelings about aged workers, Americans have evolved few successful vocational programs for this group. The current attack upon the problem seems to be partialistic, half-hearted and expedient. There is little evidence of commitment to career preservation and extension for the older worker. If anything, he is regarded as an irritant whose presence diverts us from our preoccupation with youth. Hopefully, the Older Americans Act and the recent reorganization of the U.S. Department of Health, Education, and Welfare will promote greater national concern for the vocational problems of the older worker...Perhaps, the difficulty lies not so much in older persons themselves as in society's inability to come to grips with its own feelings about employment for the aged."[1]

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[1] Herbert Rusalem, Ed.D., The Vocational Adjustment of the Older Disabled Worker: A Selective Review of the Recent Literature* (New York: Federation Employment and Guidance Service, 1967), p. 5; p. 7.

* Volume II of Final Report of Project RD-903-P, in Three Volumes. The project was supported in part by a Research and Demonstration grant from the Vocational Rehabilitation Administration. Titles of Volumes I and III: Rehabilitating the Older Disabled Worker and The Vocational Rehabilitation of Neighborhood-Bound Older Disabled Persons: A Program Guide, each authored by Herbert Rusalem, Ed.D., Roland Baxt, and Irving Barshop.

The concern in Ohio for suitable methods of assisting those with problems evolving from the process called aging was dramatically spotlighted by the Governor's Conference on Aging held in Columbus May 28, 1968. The conference, sponsored by the Ohio Administration on the Aging, was planned so that "Eminent speakers working in these problem areas will help set action into motion through the introduction of new thinking which will benefit the nearly one million older Ohioans currently 65 years of age and over, and those persons who in the near future will be added to this list."[1]

Prior to the Conference on Aging, the Ad Hoc Committee on the Aging, established to incorporate recommendations in this area into the two-year study on vocational rehabilitation in Ohio, held a series of meetings and submitted a report to the Governor's Council on Vocational Rehabilitation. Committee members included Mrs. Rose Papier, Coordinator, Administration on Aging; Dr. Fred Cottrell, Department of Sociology, Miami University; Dr. Martin D. Keller, Director, Division of Epidemiology and Biometrics, Ohio State University; Jerome Kaplan, Executive Director, Mansfield Memorial Homes, Inc., and Mrs. Muriel Allen, President, Ohio Association of Centers for Senior Citizens.

Report of the Ad Hoc Committee on the Aging

a. Basic Considerations

Statistics indicate that 28.7 percent of the population is over 45 years of age. Further statistical analysis indicates that of the number of persons over 65, only 4.5 percent are free from any disability. Last year's report of clients rehabilitated by the Bureau of Vocational Rehabilitation indicates that 674, or approximately 18 percent, were people age 45 or over. Based upon statistical estimates, an equitable application of BVR services to the age group 45 and over would require at least the doubling of services and funds.

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[1] Ohio's Heritage,* Vol. 1, No. 3,(March-April 1968), p. 1.

* Publication of the Ohio Administration on Aging, Department of Mental Hygiene and Correction.

The Committee resolved that their aims and goals should be directed toward general rehabilitation rather than toward the vocational aspect. Though it is a fact that the therapy of working is an important part of the rehabilitation program, there is an acute problem in encouraging employers to accept the older person. To provide the older person with a job compatible with his background and skills is very difficult. The competition with younger people is quite severe in most job situations.

Aging is a problem that will become more acute in the next five to ten years as we are faced with a growing population with more people reaching the years associated with retirement and old age. There is an estimated 40 to 50% increase.

There is a distinct need for preplanning for retirement and vocational readjustment for those 45 and over. Executive and legislative action is needed to end the age barrier to employment.

Extensive education and redirection of the thinking of counselors, employment and social agencies, as well as employers, on the possibility of using the services of the aging is necessary.

Disability liability and insurance costs, which make the employer reluctant to hire persons 45 and over, must be overcome.

We must devise a system to meet the needs of the aging. The initiation of programs to develop centers for the aging and social rehabilitation facilities is required, to motivate the aged person to a wholesome self-image.

A system similar to Social Security benefits is needed to remove the stigma of welfare from any assistance that might be developed to allow the aging to meet their economic and social obligations.

A carefully directed study is required to investigate the needs of the aging and develop planning to meet those needs.

b. Supportive Findings and Conclusions

The findings and conclusions were a result of general discussion by Committee members and available statistical data.

Approximately 20 percent of the population in the State of Ohio are between the ages of 45 and 64.

Approximately 9.2 percent of the population in Ohio are over 65.

All persons who are 50 years of age or older are estimated to have disabling conditions that impair their function by an average of 10%. Many people over age 55 have multiple disabilities.

12 percent of the 3,600 people rehabilitated by BVR last year were between the ages of 45 and 55.

5.5 percent of the people rehabilitated in the same year in Ohio were between the ages of 55 and 64.

In that year, 7 percent of the people rehabilitated in Ohio were 65 and over.

54.2 percent of the disabled aged 44 and over who were rehabilitated by BVR had orthopedic or amputee disabilities.

19 percent of the BVR rehabilitants aged 44 and over were mentally disabled.

13 percent of those rehabilitated by BVR in this age group had speech and hearing impairments.

There were no rehabilitation cases in the BVR for the socially disabled over 44 years of age.

There are an estimated 800 Senior Citizen Centers in Ohio at the present time, with a good indication this will reach more than 1,000 by 1969.

Though the gain in overall percentage of population is slight in 1967, 1975, and 1990, the people age 45 and over will comprise a portion representing a percentage increase from 40% to 52% by 1990.

There is a need for comprehensive vocational rehabilitation centers to serve all age groups, including the people age 45 and older.

There is a distinct need for a study to develop a comprehensive program to realize the maximum potential from funds, facilities, resources, and people.

There is a need to develop pre-retirement and continuing adult education programs. Educational academic settings must be adjusted to accommodate all age groups, especially the older Americans.

There is a dire need for better use of existing facilities such as schools, institutions, and training facilities of private agencies as well as industrial facilities.

Teachers must be encouraged to change concepts regarding the education of the adult and the need for continuing education.

Industry and labor must be solicited to provide avenues to assist in the rehabilitation of the aging.

The age anti-discrimination law (Public Law 90-202) must be supported at state, county and community level.

Rigidity and traditional ideas must be removed so that the emphasis on rehabilitation will include all ages.

There is a need for a consolidated effort in conjunction with the model cities program and all other programs, Federal and State, to develop comprehensive rehabilitation for all age groups, including the older American.

There is a need for an on-going planning group to work in all larger communities to coordinate planning and objectives of the various studies and planning projects.

Transportation is a very difficult problem. There is a need to provide a solution to problems involved in the moving of clients to and from facilities. Suburban areas of some larger cities, and cities with smaller populations, have little or no means of transportation.

More emphasis must be put on post-release services and the half-way house concept. This would relieve the shortages in bed space in hospitals and institutions.

There is a need for a demonstration planning project funded federally or by private funds to develop a pilot program to effect total services.

A Model for Action

Federation Employment and Guidance Service, New York City, in a project supported in part by a research and demonstration grant from the Vocational Rehabilitation Administration, has already designed and implemented a planned program to effect recommendations, and to meet needs of the aging, through action embodying concepts similar to those presented in the report of the Ad Hoc Committee on the Aging to the Governor's Council.

The results of this pioneer project are so forceful as to warrant intensive study by anyone working in the field of human services, for those results have broad application to the total spectrum of human needs and resources. More emphatically should this project be given serious consideration by rehabilitation workers and, indeed, by any rehabilitation agency genuinely interested in fulfilling its mandate to serve the older American. For these reasons, excerpts from the final report of the project provide a fitting conclusion to this discussion of rehabilitation for the aging.

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a. Highlights[1]

During the five-year period 1962-66 Federation Employment and Guidance Service (FEGS) conducted a six-phase vocational rehabilitation program for older disabled workers, coordinating central facility services with the services of two neighborhood-based programs. This organizational pattern enabled the project to provide vocational rehabilitation to a whole spectrum of older disabled clients ranging in capacity from the highly mobile (served in the Central Facility) to the seriously limited (including home-bound, hospitalized, institutionalized, and neighborhood-bound individuals), all of whom were eligible for state vocational agency services.

More than 1,500 clients were served. These clients had a mean age of 59.6 years, a mean educational level of 7.7 years, and a mean period of unemployment of 2.8 years. Cardiac and orthopedic conditions predominated. Clients received a combination of services adapted to their individual needs including intake, workshop, psychological, and interview evaluations, personal adjustment training, counseling, placement, long-term workshop employment, and follow-up.

b. Value[2]

The data emerging from this experience are unequivocal. Resistance to vocational services for aged disabled persons no longer has any basis in fact. Given reasonable opportunities to overcome the major effects of their disabilities, older disabled persons can achieve employment success.

c. Selected Conclusions[3]

A comprehensive multi-stage vocational rehabilitation program for older disabled persons is practical, even for those who are so disabled that they cannot leave the immediate vicinity of their place of residence regularly for rehabilitation services and employment.

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[1] Rusalem, Baxt, and Barshop, Rehabilitating the Older Disabled Worker, Inside Front Cover.

[2] *Ibid.*, p. v.

[3] *Ibid.*, pp. 83-84.

Such a program may be conducted at reasonable levels of cost and efficiency if adequate community and state rehabilitation agency support are available.

Most individuals who are vocationally motivated despite advanced age and severe disability retain sufficient vocational potential to justify admission to a specially designed vocational rehabilitation program.

Regardless of vocational potential, an older disabled client's progress is likely to be influenced most strongly by his immediate involvement in remunerative work. The ultimate effectiveness of this work therapy usually is heightened by the provision of such supportive services as evaluation, counseling, training, and placement.

A vigorous placement program can obtain successful placements for a large majority of older disabled clients who qualify for entry into industry subsequent to rehabilitation. As may be expected, this varies from time to time, depending upon general labor market conditions.

Older disabled clients who participate successfully in a vocational rehabilitation service almost uniformly experience financial gains which make possible increased comfort and an improved social outlook. No less important, however, are the positive changes that occur in client self-perceptions, increased acceptance of the client by the family and the community, and the opening of new outlets for social expression. In general, participants in such a program may be expected to achieve improved social and community relationships and enhanced physical and emotional well-being.

Without major disruption of existing programs and without depleting available resources, projects similar to the FEGS service can be established in many cities and, probably, in some rural communities, as well.

A major deterrent to the development of such programs is a generalized apathy toward the vocational needs of older disabled persons. If nothing else, this project has confirmed the fact that such needs exist and that special vocational rehabilitation programs designed expressly for older disabled persons can achieve positive results, even for those who are confined to their neighborhoods, their homes, or the institutions in which they reside.

Using the FEGS Program guidelines presented in Volume III section of this report, other agencies may enter this specialized field of service with a minimum of risk. In most respects, the route toward a comprehensive program is well-charted. Although additional study is needed, the FEGS experience already provides sufficient justification for immediate entry of other agencies into this area of client service.

d. Selected Recommendations[4]

Comprehensive vocational rehabilitation programs for older disabled persons similar to the FEGS model should be established in urban communities throughout the United States.

Experiments should be planned in the development of vocational programs for older persons which would become integral units in multi-disciplinary and multi-function service centers for the aged. Within such centers offering social, psychological, educational, and vocational services, the vocational program should be conducted by specialized vocational agencies having competence in this sector of community activity.

Public and private agencies should be encouraged to develop improved services to vocationally-motivated older disabled persons. Although the FEGS Project stressed differentiated programming for aged clients, much can still be done for this group within general vocational rehabilitation programs whenever special programs are not possible.

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[4] Rusalem, Baxt, and Barshop, Rehabilitating the Older Disabled Worker, p. 85

Increased financial support should be granted by government to long-term workshop employment programs, especially when clients require subsidies and workshops incur heavier than usual operating costs.

Welfare department caseloads usually contain a proportion of older disabled persons who have residual vocational potential. Cooperative programs following the FEGS model established between rehabilitation services and welfare agencies can assist many of these individuals to achieve at least partial self-support, thus reducing welfare costs and enhancing client self-respect.

Although the FEGS Project concerned itself almost exclusively with older disabled persons, some experience was gained with other client groups as well. Their experiences were so favorable that additional experiments of this type with all disabilities are recommended. Concretely, FEGS proposes a central-neighborhood facility approach that would concentrate upon serving all the accessible physically, intellectually, and emotionally disabled persons within a neighborhood through a comprehensive locally-based vocational rehabilitation service.

e. Challenge[1]

We hold that if a person strongly believes in something that is good he may get others to believe in it too. With this thought in mind, we commend the FEGS report to the attention of rehabilitation administrators, planners, and practitioners. Here are the methods which can be used to improve the adjustment of the older disabled vocationally motivated client, and the techniques to upgrade his skill and his ability to work at the highest level of capacity remaining to him. And, for the older person to whom advancing years and increasing disability deny the opportunity for work, here is a program of substitute activity in sheltered workshops to enable him to continue useful and satisfying participation in his community. Hope is especially the anchor of life for this group of our citizens.

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[1] Mary Switzer, in the Foreword to the Final Report Volume I, Rehabilitating the Older Disabled Worker, pp. iii-iv.

2. The Disadvantaged and Deprived

One cannot define economic, social, and cultural deprivation, but those who suffer from such deprivation are keenly aware of its repercussions. More and more, Americans who can avail themselves of the economic, social, and cultural advantages present in our society are also becoming aware of those repercussions. Thus, while arbitrary income-level, status-level, or educational-level delineations cannot be agreed upon as definitive, the pressing problems of strife-torn inner-city ghetto residents and the cycle of impoverishment, illness, and hopelessness following the seasonal route of the migratory worker are concrete manifestations of deprivation easily recognized by its victims and their neighbors alike.

"For decades social workers and others interested in social policy have been calling attention to the social causes and effects of poverty, disease, squalor and crime. By arousing public sentiment and promoting social action, they contributed to the acceptance of public responsibility for meeting these problems.

"The anti-poverty program enacted in 1964 has brought into the full public spotlight the problems of poverty, deprivation, and disadvantage, which the social work profession has been combating for decades. Poverty and dependency are now prime concerns of people in the power structure. The problems are openly discussed in the public media and debated in congressional circles."[1]

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[1] Wilbur J. Cohen, "Social Policy for the Nineteen Seventies," Health, Education, and Welfare Indicators (Periodical of the Department of Health, Education, and Welfare, May, 1966), p. 3.

A New Direction

In facing the problems of the disadvantaged and deprived, no simple solutions are readily available. Simple solutions, indeed, would prove no solution at all in areas with so many complex interrelationships and so many variable factors. The tried policy of dealing with such domestic problems has not provided relief. Many see a new direction for public welfare programs as both desirable and mandatory. The following words, written in 1961, have not lost their force for the present:

> "What is this new direction in which public welfare must go? It is movement toward the prevention and control of the basic social problems which families present and toward the rehabilitation of these families whenever possible. For the past twelve years CRA has recognized this need for change in public welfare goals and has conducted research demonstrations to develop effective tools for use in prevention and rehabilitation. Secretary Ribicoff knows there is need for change. Last May before the National Conference on Social Welfare, and last month in Cleveland, he stated that the country is 'just drifting' in the field of welfare. 'First,' he said, 'public welfare must be more than a salvage operation, and it must not be confined to picking up the debris from the wreckage of human lives. Its ever-growing emphasis should be on rehabilitation and prevention.'"[1]

Coming to Terms With Deprivation

The term welfare, as defined in Webster's Seventh New Collegiate Dictionary, connotes "the state of doing well esp. in respect to good fortune, happiness, well-being, or prosperity." Paradoxically, the term has come to mean, in common usage, the last resource of those who are not doing well in any of these respects.

Some of the factors that enter into good fortune, happiness, well-being, and prosperity are those essential economic, social, educational and cultural accretions that build an individual into a whole person, able to meet himself and the society of which he is a part with honor and respect. Deprivation begins to compromise the individual's honor and respect in early childhood, when he is faced with school programs directed toward the advantaged and non-deprived, and continues to compromise him throughout his adolescence into adulthood.

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[1] Harry O. Page, A New Direction for Public Welfare (New York: Community Research Associates, Inc., 1961), pp. 6-7.

"Thus, for the therapist to work effectively with the patient he must understand not only the patient's social systems, but his own as well. Such understanding will provide important clues to the common areas and differences between them in rehabilitation planning. For example, the therapist, in common with most professionals, may be operating on the wave length of middle class values while his patient may be tuned in on another value frequency. This differential value orientation seems to be at the heart of our difficulty in dealing with the culturally disadvantaged. The recent President's Crime Commission report, for example, asserted that middle class teachers were instrumental in fostering juvenile delinquency because of their lack of understanding of pupils with lower social class values. This difference generally leads to an impasse where the therapist in exasperation or in a might-makes-right display attempts to impose his will upon the patient. Such an approach is a prelude to disaster and the patient is eventually characterized as unmotivated."[1]

a. Dimensions of the Problem[2]

Limited Alternatives

The poor, of all the strata in society, have the slightest opportunity to experience varieties of social and cultural settings. Their own setting is one of the least intricacy and flexibility. Throughout life, they experience a very narrow range of situations and demands. Their repertoire of social roles is limited. They seldom participate in any activity which takes them out of the daily routine. They rarely play roles of leadership, or fill any position calling for specialized functioning. On their jobs they confront less complex situations and have fewer, less diverse standards to meet. Socially, they seldom go beyond the borders of kinship and neighborhood -- people very like themselves.

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[1] Margolin, "Impact of Social Systems Upon Rehabilitation of the Disabled."

[2] "Life Conditions of the Poor", in Low Income Life Styles, ed. Lola M. Irelan (Washington: Division of Research, Welfare Administration; Department of Health, Education, and Welfare, n.d.), pp. 1-3.

Helplessness

The position of the poor vis-a-vis society and its institutions is one of impotence. They have practically no bargaining power in the working world. Unskilled and uneducated, they are the most easily replaced workers. The skills they do have are minimal, of little importance in productive processes. On the job itself, the very poor man can exercise little autonomy and has small opportunity to influence conditions of work. He is close to helpless even to acquire information and training which would change this situation. He has neither the knowledge nor the means to get it.

Deprivation

It is reasonable to suspect that this general condition, almost universally associated with poverty, is felt with particular intensity in American society...When it is defined as lack of resources relative to felt wants and needs, it is evident that America has one of the greatest gaps between generally accepted goals and the extent to which the lower class can realistically expect to attain them. The richness of life in the rest of society is well displayed -- on television, in newspapers, on billboards, in store windows, on the very streets themselves...Their relative deprivation is perhaps, the condition which more than anything else affects the life-view of the poor. Constant awareness of their own abject status and the 'failure' which it rightly or wrongly implies understandably leads to embarrassed withdrawal and isolation.

Insecurity

People of low income are more at the mercy of life's unpredictability than are the more affluent. Sickness, injury, loss of work, legal problems -- a range of hazardous possibilities -- may overwhelm anyone. But to the poor man they are especially fearful. His resources are more sparse ...Certain conditions of his life make emergencies more likely...An emergency expenditure of funds may mean the postponing of rent payments and the fear of eviction...He often finds that he cannot successfully navigate the channels involved in using public sources of emergency help, such as clinics and legal aid agencies.

b. Findings of the Advisory Council on Public Welfare[1]

On all counts and from all sources the weight of the evidence is incontestable: a major updating of our public welfare system is essential if it is to fulfill its assigned task of assuring a basic floor of economic and social security for all Americans. The remedies must match these indictments:

Public assistance payments are so low and so uneven that the Government is, by its own standards and definitions, a major source of the poverty on which it has declared unconditional war.

Large numbers of those in desperate need, including many children, are excluded even from this level of aid by arbitrary eligibility requirements unrelated to need such as those based on age, family situation, degree of disability, alleged employability,low earnings, unrealistic requirements for family contribution, durational residence requirements, and absence of provisions for emergency assistance.

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[1] "Having the Power, We Have the Duty," Summary of Recommendations to the Secretary of Health, Education, and Welfare; The Advisory Council on Public Welfare Report to the Secretary of Health, Education, and Welfare (Washington: U.S. Government Printing Office, June 29, 1966).

The methods for determining and redetermining eligibility for assistance and the amount to which the applicant is entitled are, in most States, confusing, onerous, and demeaning for the applicant; complex and time consuming for the worker; and incompatible with the concept of assistance as a legal right.

The lack of adequate social services for families, children, young people, and individuals isolated by age or disability is itself a major factor in the perpetuation of such social evils as crime and juvenile delinquency, mental illness, illegitimacy, multigenerational dependency, slum environments, and the widely deplored climate of unrest, alienation, and discouragement among many groups in the population.

Neither the war on poverty nor achievement of the long range goals implicit in a Great Society concept can succeed so long as the basic guarantees of a practical minimum level of income and social protection are not assured for all.

c. Selected Recommendations: Regional Task Forces

Immediate action should be taken on behalf of the socially disabled. (Region I)

We recommend that present programs be adapted to reach and motivate the socially and economically deprived; through more adequate subsistence grants, basic changes in school systems toward serving the "culturally deprived," and creation of job opportunities. (Region VI)

We recommend that programs be planned to provide year-round employment and respectable incomes for all family and individual needs; that rehabilitation services include the guiding and encouraging of those who need help when they face the maze of preliminaries to jobs; that those who enter training programs be provided with realistic support income, as well as the necessary ancillary needs such as day-care for children and health services, and that the state rehabilitation agency act as coordinator among the various programs; that, because dead-end jobs tend to prevail for the low-income individual, many more training programs for jobs with futures should be developed. (Region V)

3. The Public Offender

"The public offender is a failure in society. He has failed his family, he has failed in his job, and he has even failed as a criminal...The problem of the public offender does not actually start when he is imprisoned, but prior to incarceration. He is a public offender only because he has been apprehended, tried, convicted, and sentenced. Three-quarters of the crimes committed today in the United States are committed by people who have already been in prison."[1]

There is an unquestionable relationship between disability, deprivation, disadvantage and those actions socially unacceptable in our society to the degree of being punishable by law. Students of personal and group psychology speak of the relationship in terms of social dynamics, pressure/reaction patterns, and self-other orientation. Statistics speak of the relationship in terms such as the following:

Of the total sentenced population, 25.5% were Negro. The median age was 31.7 years. Frequent offenses were Narcotics (15.8%), Postal and Bank Robbery (9.7%), Forgery (7.2%), Larceny (other than Motor Vehicle) (5.9%), and Liquor Laws (5.2%). The highest average sentence among these offense categories was 168.6 months, for Robbery, followed by 88.8 months (Narcotics), 46.5 months (Forgery), 43.0 months (Larceny other than MVTA). Juvenile cases accounted for 4.2 percent. There were 1,132 commitments sentenced under the Youth Corrections Act, 317 with Minority ("until age 21") sentences, and 10 with Life sentences. Of the total committed from court during fiscal year 1966, 7,439, or 60.1 percent, had one or more known previous commitments. Of those persons with known previous commitments, 2,255 had one prior commitment, and 5,184 had two or more. 1,690 (13.7 percent) were divorced. There were 1,744 parole-violator warrants issued by the Board of Parole during fiscal year 1966 (31.3 percent of the parole releases).[2]

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[1] Federal Bureau of Prisons Statistical Report Fiscal Year 1966 (Washington: Research, Statistics & Development Branch, Federal Bureau of Prisons; U.S. Department of Justice, July, 1967), pp. 1-5 passim.

[2] Ibid.

The public offender is often bred in the centers of economic, social and cultural deprivation; he is often sentenced for behavior related to misuse of alcohol or drugs. In the public offender, the alcoholic and the drug addict, are concretely manifested the broader problems of mental and social disability; and, indeed, these are more and more being studied in the light of biochemical and physical factors that can be causal to, as well as resultant from, such disabilities. Yet it is with the concrete manifestation that the rehabilitation agency and its staff are first confronted in their efforts to plan an effective rehabilitation program.

a. Contributing Factors in the Need for Rehabilitation

In the public offender, the rehabilitation team is faced with several factors that together may indicate, or even determine, the nature of the services that must be provided in addition to those basic rehabilitation services the client's adjustment level and potential would demand were he not confronted with the stigma of being a public offender.

Public Sentiment

The willingness of the public to refrain from charging an ongoing interest on the debt the offender has already paid will vary from community to community. Yet, in no case can the usual reluctance of the general public to expect constructive citizenship from the client be ignored. Most important is the special public made up of business, labor, management, personnel officials--all those who represent the potential employer.

It is vital that the public relations program of any rehabilitation agency contain special provision for educating the potential employer to accepting those persons with stigma-related disabilities into their list of job applicants, and to considering such applicants in the light of their skills and work experience as related to the job opening. Unemployment contributes to recidivism; conversely, acceptance by an employer tends to reduce lack of acceptance by family, neighbors and the community to a significant degree.

Public relations on behalf of such clients must be effected by an on-going public education program to gain community support, and must be supplemented by the rehabilitation counselor through specific employer contacts on behalf of his client. In this area the advocacy role of the rehabilitation agency is forcefully exemplified.

Setting at Time of Initial Contact

Another important factor contributing to the nature of the counselor's role is the setting in which he is introduced to the client. In instances where rehabilitation units have been incorporated into penal or correctional settings, the rehabilitation concept can be introduced into the client's total correctional and pre-release program. The client may have his initial contact with the rehabilitation agency at the time of probation or parole. He may meet the counselor during the transitional stages of his re-entry into the community, while he is residing in a half-way house. Finally, he may seek the help of the rehabilitation agency only after re-entry and prior to job placement.

The ability of the counselor to plan an effective rehabilitation program of comprehensive services to the whole person is contingent upon the setting in large part, because even the most favorable time period, represented by initial contact through a rehabilitation unit in the correctional institution, allows less flexibility in terms of time than for other clients.

"The professional counselor has felt that through the application of his skills and knowledge a vocational rehabilitation plan could be made which would outline the vocational objective and the steps necessary to reach that objective. There has been a tendency for counselors to evaluate their effectiveness on the basis of the number of clients who follow the plans made and accomplish the stated objective. These feelings have been shared by the agency administrators. This program has indicated a need for reevaluation in this disability group of holding strictly to this criterion. Particularly in the early phases of the program many plans were made which called for relatively long periods of training after the client's release. Very few individuals were able to follow this plan to completion. Apparently, one of the major characteristics of this group of individuals is their inability to postpone gratification of their needs. Yet, a relatively long training period requires just this kind of postponement. As a result, the instances in which the follow-up counselor had to revise the vocational plans to a lesser skill level were many."[1]

Setting to Which Client Must Return

Still another factor entering into the rehabilitation potential of the public offender is the environment to which he must return.

A Welfare Administration study in Sacramento, California showed that substandard housing areas produced 36% of the city's juvenile delinquency and 42% of the city's adult crime.[2] If the offender's home and family are located in a blighted area, it is there that he will likely take up his life outside the confines of the correctional institution. If he has no home or family, his economic status may force him to assume residence in such an area. In either case, he will be subjected to the immense pressures of the urban slum, and the consequent exposure to opportunities for repeated criminal activity.

Even should the public offender be able to return to an environment more conducive to wholesome response patterns, he will be marked as an antisocial person, feared, and shunned, sometimes even by close associates and friends of his family. He will likely have little opportunity to receive encouragement and support from others who share his handicap, unless he has access to a half-way house program or to group therapy and group discussion sessions with other persons on probation or parole.

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[1] Rehabilitation of the Young Offender: A Cooperative Program of Correctional Rehabilitation* (Oklahoma: Vocational Rehabilitation Service and State Reformatory, April, 1967), p. 44.

* Final Report of a Research and Demonstration Project supported in part by a grant from the Vocational Rehabilitation Administration, Department of Health, Education, and Welfare.

[2] Welfare Administration Publication No. 20, Cities in Crisis: The Challenge of Change (Washington: U.S. Government Printing Office, 1967), pp. 4-5.

In working relationships, once he has been placed into employment, he may find that he must prove himself superior before he can be accepted as equal. Absenteeism, tardiness, failure to follow instructions promptly and accurately, and even ordinary reactions of dissatisfaction or resentment may be accepted from him much less readily than from other employees.

b. Approaches to the Rehabilitation of the Public Offender

"The public rehabilitation program views crime and delinquency as primarily the problem of individuals. Thus its focus is on the individual and his attempts to establish for himself a satisfying identity and a rewarding vocational role. Vocational rehabilitation programs have been aimed at providing the individual with the opportunity to develop the necessary abilities and skills to enable him to participate actively in the community and to gain in both personal dignity and competence. The area of employment has been shown to be an effective setting for efforts designed to reduce crime and delinquency."[1]

The assistance of the public offender into suitable employment that will restore his self-confidence and dignity, and enable him to continue as a law-abiding citizen through accepted roles in the community, is the challenge facing the rehabilitation counselor working with this special group of the socially disabled, whether his contacts with the client occur prior to, or following, his release from the correctional institution. As indicated earlier, a rehabilitation emphasis within the institution and designed as an integral part of the correctional program is most likely to effect successful transfer of the offender from the prison setting into the community and into suitable employment.

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[1] "Correctional Rehabilitation", Rehabilitation Record, July-August 1967, p. 33.

Pre-Release Programs

"The counselor has a peculiar advantage in dealing with the inmate of a penal institution. The inmate has little or no choice in anything he does. He is completely regimented. He is surrounded by individuals whom he inwardly fears and distrusts. This fear extends not only to fellow prisoners but to guards and prison personnel. Not being in either category, the vocational worker is in a position to exert tremendous influence upon the inmate. The occupation he teaches and the guidance he gives should become, in most instances, the most important factor in the inmate's prison life.

"The result of the influence exerted by the rehabilitation worker depends upon his rapport with the inmate and the pattern set by the instruction. The pattern sought is merely the mold or the form which the inmate will use as his own guideline in which to shape his future.

"An inmate in a prison has been taken away from all he cherishes. He has been removed against his will from his familiar surroundings and friends. He is left in a strange environment filled with anxiety, fear, and rejection. This program grants him an opportunity to fill this void, and provides him with a means, in fact, to pay his debt to society."[1]

Perhaps the true debt to society is the debt the offender owes himself--the right and the responsibility to live fully and freely, with dignity and honor, as a respected member of the family of man. Incarceration will not discharge that debt to society or to himself, unless its purpose is rehabilitation--preparing the public offender to become an independent, contributing private citizen.

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[1] William A. Berry, "Crime and Punishment," in "Rehabilitation and the Public Offender," Rehabilitation Record, November-December 1965, p. 31.

The Re-Entry of the Offender into the Community

"Parole may be defined as post-institutionalization care of the offender that is legally compulsory and usually lasts for an extended period. It is a time of qualified freedom for the offender, based on the assumption that, on the one hand, he no longer needs to be incarcerated but, on the other, is not yet prepared to assume a full role in society without a trial period of observation and supervision. At any time during the parole period, the offender is subject to reincarceration should he fail to meet criteria established for his behavior. Thus, parole becomes that most critical time in the life of the offender, during which his continued freedom depends upon its successful completion.

"It is a disconcerting fact to those working in corrections and law enforcement that the majority of offenders fails to successfully complete parole. The consequences of this excessive rate of failure, while serious for the offender, are critical for society, for it is the community that will suffer in the long run from the inability of individual members to behave in an acceptable fashion."[1]

In fiscal 1966, of the 9,980 Ohio residents on parole, 994 were returned or reentered under new sentence.[2] Although no indication is given in this report as to training and experience requirements for applicants for the position of parole officer, it describes the Orientation and Training School for new officers during 1966. The school consisted of six sessions, held one day monthly for six months, and comprising a "study of the complete parole process from the history of parole through the discharge of the rehabilitated offender. After the sixth session, class members undergo examination and are awarded Certificates of graduation. These officers also receive training in the units to which they are assigned and generally spend the first few days on the job in the office, becoming familar with rules, report forms, clerical operations, and with other personnel. They then go into the field with a veteran officer for a few weeks, after which they return to the parole office for additional familiarization with procedure. Caseloads are built up gradually."[1]

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[1] Bernard Russell, "Foreword," in Elliot Studt's The Reentry of the Offender into the Community, STUDIES IN DELINQUENCY (Office of Juvenile Delinquency and Youth Development, 1967), p. iii.

[2] Annual Report: Ohio Adult Parole Authority--July 1, 1965-June 30, 1966 (Columbus, Ohio: Department of Mental Hygiene and Correction, n.d.) p. 28.

The role of the parole officer is critical to the success of the parolee in his reentry into the community. There is, however, no complete agreement as to what that role should be. "Parole personnel are strongly influenced by two opposed definitions of the parole task, each of which has its spokesmen among high-placed officials and adherents who maintain the ideology as dogma and orient new parole agents to their views. One definition of the parole task, parole as surveillance, conceives of the parolee as a person who must be continually policed if he is to fulfill any of his role obligations. For officials subscribing to the surveillance ideology, success in parole work is measured by the proportion of parolees discovered in rule violations and returned to the institution.

"The other definition, parole as treatment, conceives of the parolee as an inadequate, confused, often sick individual who must be controlled and counseled if he is to overcome the problems resulting from his incapacity. According to the treatment ideology, success in parole work is measured by the proportion of parolees helped to stay out of the institution.

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[1] Annual Report: Ohio Adult Parole Authority--July 1, 1965-June 30, 1966 (Columbus, Ohio: Department of Mental Hygiene and Correction, n.d.) p. 13.

"In neither ideology is there likely to be a conception of the parolee as a person with good intentions who is faced with an unusually difficult adaptive task; nor of the parole task as providing the most favorable possible conditions to support the parolee's attempt to complete his status-passage successfully."[1]

The rehabilitation concept includes both the adknowledgment of the public offender as a person, assumed to have good intentions, who is faced with an unusually difficult adaptive task, and the realization of the need to provide the most favorable conditions possible to support his reentry into the community. The extremely difficult role of the parole officer could well be supported and enhanced by cooperative efforts with rehabilitation counselors working at the community level to further the parolee's efforts in this regard. Additional support through halfway houses and group therapy / group discussion programs might further strengthen the individual in his search for a new identity.

Special Needs of the Youthful Offender

One interesting view of our present society groups youth, Negroes, and the poor as alike in having "subcultural value systems different from, yet subsidiary to the larger culture. They often share many features, such as being deprived of certain civil rights and liberties, barred from voting, and denied adequate defense counsel and equality of justice...their power to effect change in their futures may be minimal...There is among youth, Negroes, and the poor more deviant and criminal behavior, and a greater disparity between aspiration and achievement...With more clarity and conscience, the three groups are searching for meaningfulness, identity, and social justice."[2]

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[1] Russell, The Reentry of the Offender into the Community, p. 13.

[2] Marvin E. Wolfgang, The Culture of Youth, STUDIES IN DELINQUENCY (Washington: Office of Juvenile Delinquency and Youth Development, 1967), pp. 20-21.

Seeing the youthful offender as one who has chosen unacceptable behavior as a means of seeking power and participation, this view reflects the conviction that "The freedom to be assertive, to defy authority and orthodoxy may sometimes have such consequences as crime and delinquency. But it is well to remember that many aspects of American ethos, our freedom, our benevolent attitude toward rapid social change, our heritage of revolution, our encouragement of massive migrations, our desire to be in or near large urban centers, and many other values that we cherish, may produce the delinquency we deplore as well as the many things we desire."[1]

It is imperative that rehabilitation program planning include special planning toward rehabilitation of the youthful offender. As is true in other areas of rehabilitation, correctional rehabilitation is more likely to be effective and long-lasting when it occurs in the earliest possible stages of disability, before chronicity sets in. For the youthful offender it is especially important that the comprehensive approach offered by rehabilitation services be employed.

"Recent delinquency-prevention programs, especially those in deprived areas where the employment structure has been limited, have attempted to increase the availability of jobs and the use of job placement as an integral part of the treatment program for delinquent adolescents. However, most of these programs have also been aware that delinquents have more severe problems than just lack of employment. Most delinquents are far behind their age-grade level. Their basic skills in reading and arithmetic are very meager. (Studies have demonstrated that their intelligence is usually in the normal range.) Thus, having done poorly in school, they are academically unprepared for most work situations. Delinquents also have poor social skills. They find it difficult to deal with the authority figure of a boss and to organize their energies toward constructive activity with people. Added to this are the many personality factors previously discussed that make it most difficult for chronic adolescent delinquents to succeed on the job. These include their marked impulsivity, low frustration tolerance, a very concrete attitude toward the world, limited time sense, inability to plan, much focus on action, and a great fear of dependency in any situation where there might be closeness to people. Although work is often conceived of by the delinquent as preferable to continuing in school, he thus has few assets that would serve to sustain him in an employment situation. As a result of the many difficulties that delinquent adolescents have, work alone is not able to solve their problems. Therefore, programs of vocational training or job placement that do not have intensive counseling incorporated in the program usually result only in temporary employment and repetitive job hunting. For that reason, although in planning a program for delinquents work may be seen as a goal, it is necessary to include other services. The delinquent adolescent, for example, needs pre-employment counseling focusing on job readiness. Severely handicapped academically, he also needs a remedial education program individually tailored to his needs and related to his work performance, so that his skills can be maintained and improved. He needs a program that also offers psychotherapeutic help when his work experience has resulted in difficulty or when he may have to discuss certain personal problems. Because of his limited time sense and inability to withstand frustration, he also needs support immediately at times of crisis and in the place of difficulty, not at hours structured as weekly interviews and set up according to a preconceived schedule by a professional person in an office setting. In essence, he needs a comprehensive, vocationally oriented treatment program involving vocational assistance, remedial education, and intensive psychological counseling. In this program these techniques must be utilized in a flexible, combined approach and offered by a single practitioner with job placement serving as a matrix for the other therapeutic efforts."[1]

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[1] Wolgang, The Culture of Youth, p. 19.

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[1] Reuben J. Margolin, Ed., The Juvenile Court and Vocational Rehabilitation (Boston: Northeastern University, Department of Rehabilitation and Special Education, 1967), pp. 33-34. (Curriculum Materials developed from a Conference April 4-6, 1967 in collaboration with the Vocational Rehabilitation Administration.)

c. Legal Framework for Rehabilitation Programs

The Federal Vocational Rehabilitation Act, insofar as it provided for rehabilitation services to the physically and mentally disabled, has always been applicable to that extent to the needs of the disabled public offender. However, with the 1968 amendments and their new emphasis on the recent category of socially disabled persons now eligible for such service, the public offender is receiving much more intensive consideration in the discussion of rehabilitation planners.

As pointed out earlier in this chapter (Cf. pp. 194-197), the entire vocational evaluation and work adjustment program provided in these amendments can be applied without reference to physical or mental disability. Specifically, the amendments define disadvantaged individuals to include, for purposes of this special program, "individuals disadvantaged by reason of their youth or advanced age, low educational attainments, ethnic or cultural factors, prison or delinquency records, or other conditions which constitute a barrier to employment" while evaluation and work adjustment services include, among other things, "outreach, referral and advocacy".

In addition, the Correctional Rehabilitation Study Act of 1965 provided funds for a three-year study of manpower needs in all phases of correction. The act was introduced in the 89th Congress by Representative Edith Green (D., Oreg.), who served as Chairman of the House Education and Labor Committee's Special Subcommittee on Education. According to Representative Green, "Witnesses who appeared before the Committee testified that there is a ratio of one psychiatrist to every 4,000 offenders in prison, one psychologist to every 2,000, and one teacher to every 400 prisoners. As staggering as these figures are, they are only symptomatic of what has occurred in the correctional rehabilitation field so far, which has been little. Many of those entering prison could be rehabilitated with the proper effort. Recidivism is high, but why not? The United States is decades behind in prison reform. The Nation has not yet settled its collective mind on what it wants from its prisons, whether they are to be punitive or whether they are to rehabilitate, whether they are to be temporary depositories to train criminals to go out and be rearrested, or whether there will be centers to treat the causes of crime."[1]

In addition to the Correctional Rehabilitation Study Act, the 89th Congress passed the Prisoner Rehabilitation Act, permitting relaxation of release rules in Federal penal institutions to help inmates get back to productive work as smoothly and quickly as possible after serving their sentences.

d. Study Recommendations

The vocational component of rehabilitation for the public offender needs to be expanded. Vocationally-oriented training programs for inmates in need of such programs should be initiated in prisons and reformatories, with appropriate linkages to community-based programs for follow-up stages. (Region II)

The close inter-relationship of social and vocational components in rehabilitation is more apparent when discussing the needs of public offenders. In-service training programs for parole officers should be initiated and/or expanded, with training focus being given to skills related to counseling and guidance. (Region II)

In-service training of parole officers should include a general overview of the Bureau of Vocational Rehabilitation, and B.V.R. counselors should understand the Parole Authority's programs, so that each agency can provide better support to the other. (Region V)

That all probation and parole staffs be expanded to provide for maximum opportunity for sentences of probation, and for effective counseling services on the part of probation and parole officers - who would have manageable case loads. (Region III)

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[1] Edith Green, in "Rehabilitation and the Public Offender," Rehabilitation Record, November-December 1965, p. 24.

Supportive services, e.g. transitional housing, temporary economic support, need urgent establishment. (Region II)

There is a great need for half-way houses so that men who leave the institution, or men who are placed on probation, will have a place to go where they will be accepted and can get the kinds of counseling and assistance they feel necessary. (Region IV)

The Committee recommends the development of a program with local industries for financial support of vocational training along with job placement for penal offenders. (Region VI)

The Committee recommends the development of a vigorous public information program on the goals of criminal rehabilitation and appropriate attitudes in law enforcement. (Region VI)

4. Alcoholism and Drug Addiction

As indicated in previous sections of this chapter, rehabilitation practice classifies disability according to the nature of the handicap to employment, rather than strictly according to the cause of disability. Therefore, alcoholism and drug addiction are seen as social disabilities although each has significant medical aspects that relate to physical and mental disability.

Both alcoholism and drug addiction have been variously considered as problems of moral degeneracy, disease, and dependency reaction; neither has escaped the stigma attached to conditions that are poorly understood and socially unacceptable. Even after long study and investigation by professionals in medicine, sociology, and psychology, the specific causes and biological-psychological effects of these syndromes in any individual client still remain something of a mystery. Movements such as Alcoholics Anonymous and the more recent Ad-A-Non have done a great deal toward mitigating social contempt for persons seeking to free themselves of dependency on alcohol or drugs; yet mistrust and aloofness on the part of associates, neighbors, and potential employers remain a major barrier to acceptance of the rehabilitated client in the community.

More than in any other area of disability, the former alcoholic or drug addict who enters upon a rehabilitation program must continue to prove himself daily, perhaps for the rest of his life. This pressure is both internal and external, and derives from the nature of the disability itself, inasmuch as one deviation from total abstinence can start psychological and biochemical reactions that effect the virtual undoing of whatever progress the client has made. Thus the motivation of the client is of paramount importance in his rehabilitation program.

More is known of the incidence and prevalence of alcoholism, and of its effects upon the individual, his family, and society than can reliably be reported about drug addiction, One reason for this may be that the purchase and consumption of alcoholic beverages is, in may states, legalized; in some states, such as Ohio, sale of alcoholic beverages is under the jurisdiction of governmental agencies that both issue permits for the sale of alcoholic beverages and regulate the receipt of taxes on such sales.

Traffic in drugs, on the other hand, takes place outside the law. Consumers are more likely to conceal their identity from operatives in narcotics traffic as well as from the conventional community members. Community members, on the other hand, are less likely to be sympathetic toward the drug addict, since the legal accessibility of alcohol excuses the alcoholic's preliminary contacts with his "crutch", whereas initial contact with drugs is seen as, in itself, the result of the client's own initiative. Despite studies showing that drug addiction sometimes is incurred as a consequence to specific medical treatment, the public sentiment toward drug addiction is still one of contempt and revulsion.

Because of these barriers to adequate research in the area of drug addiction, this report will cite some statistics related to alcoholism and indicate some findings in this area, assuming their applicability, to some extent, to drug addiction in those areas in which the two disabilities have common elements, e.g., effect on biochemistry, addictive qualities, concepts essential to therapy and treatment, and public reaction to those handicapped by such disabilities.

a. Medical Considerations[1]

Generally speaking, the disease "alcoholism" is described in terms of the result of excessive drinking patterns. Physical effects such as 'blackouts' (temporary amnesia) are involved. Cirrhosis of the liver, pancreatitis, and various syndromes resulting from brain damage may occur. Also, social deterioration described in terms of work loss, marital discord, and arrests, may be involved. These may be followed by the total loss of the individual as a socially functioning person, the resultant dependency of his family to welfare agencies, and sometimes a surrender to the 'Skid Row' way of life.

It is significant that alcoholism is rarely defined in quantitative drinking terms...More often one finds the qualitative term 'loss of control over drinking' used in describing an alcoholic. Thus a person is considered to be an alcoholic if he exhibits a drinking pattern which he cannot seem to control, and which leads to serious damage to his physical, social, and mental health.

In making a diagnosis, one must also remember that alcoholism is usually considered to be an addiction. Not only is the drinking out of control, but when an individual withdraws from alcohol, he may suffer serious withdrawal symptoms such as anxiety, tremulousness, delirium, convulsions, or a psychosis. These symptoms usually occur within a few days after the drinking has ceased and may last about a week.

After the acute symptoms have disappeared, the 'need' or desire may last indefinitely. This desire may be aggravated by emotional stress of almost any kind. Despite all good intentions or threats, the desire to drink may reach such intensity that the individual repeatedly succumbs to it. Once he does succumb, he may not be able to stop drinking until he is sick, exhausted, destitute, or arrested.

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[1] David J. Myerson, M.D., "A Consideration of Alcoholism as a Disease" in Alcoholism and Vocational Rehabilitation (Washington: Vocational Rehabilitation Administration, 1966), pp. 20-21. (Proceedings of a Workshop sponsored by the North American Association of Alcoholism Programs and supported by the Vocational Rehabilitation Administration, Chicago, January 5-7, 1965).

This recidivistic nature of the uncontrolled drinking pattern reaches the core of our dilemma...If we think of this recidivistic drinking pattern as a medical problem, we should assume that it is caused by some existing disturbances in the biological or psychological makeup of the individual...One biochemical theory of etiology exemplifies this disease concept clearly. It assumes that there is an idiosyncrasy in the metabolism of the carbohydrates that causes them to be improperly used. The individual shifts his appetite from ordinary food to a substitute one, such as alcohol. The individual so constituted finds usual foods unsatisfying and learns that alcohol satisfies this pathological appetite. He becomes habituated and then addicted to its use. He is caught in a biochemical trap. If he gives up alcohol, he suffers from a yearning that makes daily living unbearable; if he succumbs, he constantly suffers from chronic intoxication with all of its destructive effects...While this thesis is not proven, it is presented to demonstrate an example of a possible medical explanation of alcoholism.

Alcoholism can also be described in terms of pathological behavior patterns which bring the problem into the sphere of psychiatry. From the psychiatrists' point of view, the alcoholic may suffer from a passive-aggressive personality disorder...The psychiatrist assumes that certain causative experiences, plus some constitutional factors, have lead to the development of this particular personality disorder...Like the biochemical thesis, the psychiatric one is difficult to prove. Nobody knows whether this underlying personality disturbance, with its many variations, might be the cause of, or the result of the addiction.

b. Treatment[1]

The immediate complications of acute intoxication require energetic medical care and skilled nursing. Acute withdrawal symptoms include psychomotor agitation for which oral sedatives and muscular relaxants may be used as indicated with gradual reduction in dosage as the patient shows improvement.

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[1] Ebbe Curtis Hoff, Ph.D., "Clinical Treatment of Alcoholics" in Alcoholism and Vocational Rehabilitation, pp. 23-26 passim.

In the management of acute withdrawal symptoms it is sound practice to relieve the patient's distress insofar as possible without running the risk of oversedation and throwing the patient into a coma. The use of medication should be judicious, and the dangers of transferral of addiction should be borne in mind. Also, there would be no element of punitiveness. It is wise to return the patient to full consciousness and contact with reality and his problems as soon as possible.

For the hallucinating phase, including delirium tremens, specialized care is necessary in a hospital in which its management is well understood. Attendant care is necessary, and gentle restraint may be required.

Much popular misunderstanding of the alcoholic stems from a misinterpretation of his drunken behavior, its persistence and recividism. Repeated lapses into drunkenness despite treatment, are perplexing and discouraging. This is one of the reasons that the alcoholic often finds himself an unwanted patient. As long as help for the alcoholic is limited to the periods of acute intoxication, with no ongoing planned rehabilitation program, it is unlikely that much progress will be made.

Therapy aimed at rehabilitation must be thought of as long-term process which not only seeks to deal with problems and crises in the patient's life and that of his family, but also attempts to reach and correct the underlying factors. Many alcoholics require and benefit from specialized psychiatric treatment, but large numbers can be effectively helped by general practitioners and specialists in other disciplines, particularly if a therapeutic team is available.

The patient must be helped to mobilize his own motivation for treatment and to realize that his problem cannot be solved alone by unaided willpower, but that he needs continuing professional help. Total abstinence on a day-to-day basis is essential, and the patient ought to seek aid in developing insight into and acceptance of his own feelings as well as his personal, domestic, and social problems. Rehabilitation means the reintegration of the patient and his family into the life of the community as a whole. Psychotherapy, individually or in groups, should ordinarily be continued for many months at regular intervals.

Therapy is ideally concluded by mutual agreement of patient and therapist. But when a patient decides to terminate against advice, and even when termination is mutually agreed upon, it is important for the patient to understand that he can always come back when help is needed. In one respect, therapy is a lifetime process. Hopefully a point will be reached where the patient is able to rally his own resources to deal with the majority of his problems. But when overwhelming crises are faced, it is comforting to know that a reliable resource is always at hand.

c. Vocational Rehabilitation[1]

It has been estimated that out of the nearly 4 and one half million individuals suffering from alcoholism in the United States today, about 2 million are job holders. This represents about 3 percent of the entire industrial force. The total cost attributed to alcoholism in business and industry in terms of reduced work efficiency, absenteeism, training investment, cost through termination, poor public relations, excessive sick leave, and accidents, amounts to at least $1 billion per year. With such indexes of the disabling magnitude of this illness, one would expect to find vocational rehabilitation agencies routinely reaching out to help with the recovery and rehabilitation of its victims. Actually, this is not the case.

Basic recommendations are often useful to encourage agencies to move ahead. Much can be done for alcoholics, but little is being done by many VR agencies. It is hoped that the following recommendations will result in local VR and alcoholism agencies getting together to explore the potential of future joint efforts.

Clients' needs should be the center of attention. The complete array of rehabilitation services should be adapted to the client, rather than trying to adapt the client to the available service.

Decisions whether to accept referral cases must be left to the VR agencies. They should not be made hastily on the basis of one or even a few discouraging past cases.

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[1] Selections from "Chapter IX: Vocational Rehabilitation Reaches Out" and "Chapter XII: Recommendations," Alcoholism and Vocational Rehabilitation, p. 41; p. 58.

Coordination of the various services of each agency should be streamlined to avoid delays. Cross reporting must be accepted as being germane to successful coordination.

Reciprocal training programs are helpful in encouraging and developing cooperative services.

Hard core cases need new approaches on the part of both agencies. There should be continuous attempts made to develop new techniques to expand and improve existing services.

Diagnostic tools need to be refined if the clients' needs are to be determined adequately and if those needs can be met by the available agencies and services.

Administrative planning at top level should be accomplished in order to foster realistic program development and action.

d. Placement Into Employment

The preceding sections have dealt with the broad, general aspects affecting the rehabilitation of the alcoholic and, insofar as they can be applied, the drug addict. Since placement into employment is the ideal goal of vocational rehabilitation programs, this objective will be considered in the light of experience gained in working with drug addicts and their job placement. The experiences reported by staff members of Southmore House of Houston in job placement of released narcotic addicts provide insight into the need of placement services for addicts; much of what has been found in this area can prove valuable to those engaged in rehabilitation the alcoholic as well.[1]

The biggest problem a narcotic addict faces when he is released from a hospital or a penitentiary is finding and keeping a steady job. Whether he sincerely desires to abstain from drugs or whether he is seeking his first fix, employment is central to his needs and wants. It is his primary way to join the mainstream of society where he receives rewards and punishments and escapes, even temporarily, the addict subculture.

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[1] The paragraphs that follow are excerpts from the Southmore House report by: Frederick Wiener and Keith Turkington, "Job Placement of Addicts Through a Halfway House," Rehabilitation Record, January-February 1967, pp. 12-15.

Yet the internal and external barriers to getting a job are almost insurmountable. The external barriers include the negative attitudes of the employer, lack of public and private resources to assist the released addict, and the general opprobrium of the community. Diskind and Klonsky stated it well: "Picture the discharged drug addict. He is shunned by employers, by the members of the community, by community agencies. There is no one to extend a helping hand and he comes back to the same tensions and pressures, the same family, the same associates, the same environment. He is doomed to failure even before he leaves the hospital."

The internal barriers are equally obstructive to sound employment and job and training objectives. The released addict usually lacks skilled work experience and a high school diploma. In general, he qualifies primarily for unskilled and semiskilled jobs. Even more basic, his work motivation may be highly questionable, particularly if he has been in a hospital or penal institution for a long time. Added to all this is the addict's personality: "facile, demanding, dependent, young, impatient, unreliable, manipulative, and intolerant of frustration."

One recent approach to this problem has been the development of the halfway house. Southmore House is one of these. The need for this type of after-care service arose out of the general predicament of the released addict. Not only did he need help in getting a job but his many severe problems required a total approach if there was to be any hope of a successful post-hospital adjustment.

The halfway house is a protective, temporary living facility designed to accommodate a limited number of residents. A multidiscipline staff operates the house and provides basic services to the residents. The house links institution and community.

From September 1, 1964, through September 1, 1966, 71 released narcotic addicts came to Southmore House. Thirty-seven were Anglo-American, 25 were Latin American, and 9 were Negro. Their ages ranged from 17 to 59, with an average age of 31.4. The average estimated school grade last attended was the ninth. This figure is a little misleading, however, as some of the residents completed their high school education while in the institution. Even for those who did not, many operate well above what one would expect of the average high school dropout. Thirty-four were unskilled, 17 were semi-skilled, 13 were skilled, 5 had clerical or sales training, and 2 were classified as professional people.

During this 25-month period, 63 Southmore House residents were placed on a total of 138 jobs, or 2.35 jobs per resident. This means, in effect, that the resident was placed by the vocational counselor of Southmore House (or by a counselor with a cooperating agency such as the Texas Employment Commission) and the Vocational Guidance Service with an employer who was told the circumstances and history of the resident. The above figure does not include five residents who left the program before placement could be achieved or three who obtained their own jobs without letting employer know of their background.

In summary, the Southmore House experience indicates that ease of placement varies directly with the degree of job skills of the resident. Job stability is a healthy sign. Although there are no valid research findings to indicate that job stability can be equated with complete drug abstinence, the longer an addict remains employed the more certain one can be that he is drug free.

e. Study Recommendations

A coordinated network of services, with a combination of many resources and practices, must be planned to make available facilities for rehabilitation for the chronic alcoholic and the drug addict. These facilities should include the following services: intake and detoxification; in-patient diagnosis and evaluation; in-patient extended care and rehabilitation; out-patient treatment. (Region II)

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[1] Conclusion of excerpts from Weiner and Turkington, "Job Placement of Addicts Through a Halfway House," Rehabilitation Record, January-Februaru, 1967, pp. 12-15.

Supportive services, particularly housing, are in need of development. Some of the recommended kinds of housing include half-way homes; shelters for homeless men; individual rooming houses or hotels; social clubs. (Region II)

Incarceration in a prison will not benefit the drug addict. Those persons with drug addiction problems can be helped by establishing programs and facilities on a regional basis. A reasonable proposal seems to be the centralized facility with branch offices reaching out into the smaller communities. (Region IV)

Persons arrested for alcoholism should not be sent to prison, but should be sent to a center where they can receive assistance for their specific problem. Programs and facilities must be established on a regional basis whereby those persons with alcoholic problems can be helped. We must also determine throughout our facilities whether we are dealing with physical or mental problems in the case of the alcoholic and he must be treated accordingly. (Region IV)

The detoxification center should be separate from the community center or other hospital facilities, perhaps an unidentified house. The staff should include a general medical practitioner, a psychiatrist, a sociologist, occupational therapist, and a social worker. (Region V)

Wherever possible agency or institutional workers should divide and arrange their caseloads so that a specific person can be considered a specialist with the alcoholic, thus able to manage the use of confidential information. (RegionV)

CATEGORIES OF SERVICE: SPECIAL CONSIDERATIONS

Throughout the study, consideration has been given to those services needed to enable the disadvantaged and deprived to develop their potential and assume a more productive role in the community. Two particular areas of service -- intake and job placement -- were alluded to in the task force reports as having critical significance. A few pages devoted to these considerations will conclude this chapter.

A. Referral/Intake

The first processes by which the client and the rehabilitation agency are brought together are factors that determine both the actual, individual clients who will be considered for service, and the preliminary attitudes of the individual toward the possibilities that rehabilitation holds out to him. These initial stages of contact are extremely important both to the agency and the client.

Referral is accomplished in many ways: through doctors, social service agencies, other public health and welfare agencies, interested individuals, family members, or the individual in need of service (self-referral). Intake processes may include not only the completion of an application for service, but even those sessions with the counselor leading to his determination of whether the client is eligible and feasible for rehabilitation services. Important as this latter process is, it is much more easily influenced by the agency and its staff members in the light of expanded programming and broader legal jurisdictions, and can be kept efficient and effective if the agency and each individual counselor conscientiously strives to eliminate flaws from the intake process through regular review and evaluation.

Much more difficult to control is the process by which a prospective client comes to the agency in the first place. Newer concepts of "outreach" as implied in the 1968 amendments may make it incumbent upon counselors in some instances to search out the client directly. They certainly make it imperative that the agency, in effect, search him out by vastly improved referral processes and through more effective public information efforts.

It is of great importance that those who most frequently, in their daily professional activity, come into contact with individuals in need of rehabilitation services, be aware of the rehabilitation agency and have freedom of access to its offices in order that they may refer such persons for service.

Another critical need is that of educating the potential client to available rehabilitation services. In this area, there is evidence that would indicate a need for special public relations efforts geared toward the disabled in language other than the professional, middle-class value-oriented vocabulary so often associated with official publications.

William P. Richardson, M.D., noted among persons needing services a basic "ignorance of available resources and confusion and lack of understanding of how to go about securing needed care. This was often compounded by prejudice and an inadequate or distorted image of community agencies. Moreover, simple inertia, lack of motivation, and fatalism frequently prevented the seeking of care."[1]

Dr. Richardson concluded: "It is obvious that a strong program of education, guidance, and counseling is needed to enhance understanding and stimulate the seeking of appropriate help. However, this is not as simple as it sounds. We tend to think of such a program in terms of those measures to which we and others who share our middle-class ideas, values, and patterns of reaction respond. Such necessary conventional measures, if properly designed and carried out, will be effective for a large and important segment of the population. They will, however, be totally ineffective for those people who are caught up in what is coming to be called the culture of poverty, whose value scales and patterns of reaction are quite different from our own.

"If we are going to get our message to these people, if we are going to help them and motivate them to do the things we feel they need to do, it is essential that we take account of these differences. We must utilize the insights that sociological studies are giving us to develop programs that will break through these barriers and interpret the message in terms that are meaningful and appealing to them."[2]

---

[1] William P. Richardson, M.D., "Interagency Coordination: A Basic Need in Serving Handicapped Children," Rehabilitation Literature, Vo 27, No. 7 (July, 1966), pp. 194 ff. Reprints available: National Society for Crippled Children & Adults, 2023 W. Ogden Ave, Chicago, Illinois, 60612; Reprint AR-197; .10 each.

[2] Ibid.

B. Placement Into Employment

A major problem facing all those engaged in rehabilitation services lies in encouraging business and industry to accept the rehabilitated worker into employment. The extreme difficulties resulting from employer reluctance to hire such persons are especially pronounced in relation to certain disability categories such as mental illness, epilepsy, alcoholism and other stigma-related social disabilities. Such resistance on the part of employers is a major obstacle facing the rehabilitation professions in their goal of placing the disadvantaged and disabled into a suitable vocational objective.

At the same time, the deepening involvement of industry and business in programs designed to assist and employ individuals from poverty settings suggests an underlying willingness to accept social responsibility that could help transform rehabilitated clients from an untapped source of manpower into productive roles in the community through employment in suitable work settings.

Special efforts should be made through employer education programs, negotiation with labor and management, involvement of business and industry in continuing rehabilitation services planning, and legislative review, to develop realistic legal and organizational frameworks for the placement of rehabilitated clients into employment. To this end, it is recommended:

- That there be established a statewide committee, with parallel committees in each region, to continue intensive study of this aspect of manpower and its implications; that this committee be composed of staff members of the state rehabilitation agencies and representatives of business, industry, and labor; that this committee maintain close liaison with the Governor's Committee on Employment of the Handicapped in planning effective action toward solution of the problems that deter the handicapped from placement into employment; specifically:

- That this committee, using the findings of this two-year comprehensive statewide study as a framework, be charged with responsibility for informing the public, especially potential employers, of the rehabilitation process and its values; educating business and industry to the values that accrue from hiring the handicapped; encouraging wider acceptance of the handicapped worker as a valuable, competent employee; proposing legislative revisions that would effect labor-management acceptance of responsibility in providing opportunities for the disabled to become productive, self-respecting members of society. (Statewide Ad Hoc Committee; Manpower)

Regional Manpower Study Conclusions

One major bar to proper placement of the disabled and disadvantaged is the practice of using blanket physical examinations for all prospective employees of a given firm, regardless of the specific job applied for. Another major obstacle is the shroud of mystery that envelops certain classes of disabling conditions. Yet a third barrier can be found in the employment restrictions often imposed by implication by existing labor legislation.

Industry and the medical profession should be urged to cooperate in developing physical examinations that are job-related. For example, a candidate for clerical employment should not be judged by the same physical requirements as a prospective heavy-equipment operator.

Industrial management and organized labor might redefine existing frameworks to make employment practices more conducive to placement of the disabled. Greater flexibility in the physical setting of particular job stations might permit handicapped employees to work by use of special equipment or modified arrangement of general equipment in the physical job setting. The basis for consideration for job advancement could be made more flexible so that job-incurred disabling injuries might be weighted on an equitable basis with seniority in filling specific job vacancies for which the disabled employee might qualify.

General public education is needed on the nature of disability, with special emphasis on the relatively new concept of the "Socially Disabled". Again, management and unions must talk together to decide on their mutual commitment in this field.

With respect to employment of the Socially Disabled, the employer should accept the responsibility for hiring and training this group. The training should include orientation to work, including such elements as the need for reporting to work daily and on time, the worker's relationship to his supervisor and his co-workers, and an understanding of the profit-motive in industry.

A governmental tax subsidy to employers who accept the responsibility for hiring and training the handicapped - including the Socially Disabled - might encourage more participation by industry.

Legislative contributions to placement of the handicapped could be effective in assisting labor and management toward acceptance of the rehabilitated client into the labor market.

A legislative group should be appointed to study and revise existing laws and labor restrictions, so handicapped are afforded opportunity and use of their skills.

Legislative review should be made of the minimum wage structure, for possible revisions to allow:

Provision for governmental supplementation (probably through Industrial Commission funds) of severely disabled industrially injured workmen's wages, to enable employer to pay injured employees according to their productivity, and to assure the employees a [illegible] income equal to the legal minimum wage;

Adequate recognition of the function of sheltered workshops as providers of work-readiness skills for persons who are not currently capable of gaining or retaining competitive employment. More flexible interpretations of eligibility must be made for those who are permitted to be paid by the workshop less than the legal minimum wage. Special minimum wage scales applicable to sheltered workshops should more accurately reflect the productivity of the disabled employee.

Legislative review should also be made of Workmen's Compensation programs, to make legal provision for:

Mental disabilities as a condition for eligibility;

Protecting employers from further liability for the aggravated recurrence of a fully compensated disability (second injuries").

SPECIFIC RECOMMENDATIONS BY STUDY CATEGORY: SUMMARY

The intent of this chapter has been to bring together those recommendations made by regional task forces in the various study categories that have statewide significance and applicability. An attempt has also been made to draw comparisons with other state and national studies, and with rehabilitation-related literature, in order to incorporate the findings relative to rehabilitation needs in Ohio into a broader context by indicating some of the parameters of an inter-professional and national perspective.

Concurrently with seeking to indicate the broader view, this chapter has repeatedly emphasized the individual as a whole man and the need to apply insights, however sophisticated and multidisciplinary, in a client-centered manner, with intensive concern for the client as a unique and total person.

Certainly the nature of these matters puts definitive solutions beyond the scope of this chapter. Constant research and continued planning are needed to begin to answer the questions indicated here. Rehabilitation workers in each region have applied such questions to the problems in their own region, and have begun to plan for action that might solve some of those problems. The seven regional reports contain specific guidelines which each region can follow in beginning to implement the work of this two-year study. It is hoped that the similarities throughout the state indicated in this chapter will be of value to statewide planning staff in continuing the work begun by the Governor's Council and the comprehensive statewide planning project.

CHAPTER IV

SUPPORTIVE DATA

STUDY SETTING

A. Natural Resources

A land area destined to become the State of Ohio slowly evolved into its present form on some 26 million acres of primordial limestone, sandstone and shale at times covered, at least in part, by sea water, swamp, or glacier. Blest with a moderate climate, and a diversity of hills and flat lands, forest and plains, lakes and rivers, the land became rich in natural resources. With the arrival of primitive men in the area, an unending succession of cultural developments began, all being dependent upon, and strongly influenced by, the natural components of the environment.

Some of the trends in adapting to the conditions found in Ohio which have provided the cultural basis on which the present vigorous society and viable economy have developed would include the agricultural use of the land from antiquity, the use of the waterways for transportation in addition to natural land trails, and the expansion and extension of these routes primarily by Eighteenth century pioneers and traders.

Ohioans have always shown an inclination to use the resources of the area to produce manufactured articles. This characteristic ranges from the primitive pipestone and copper artifacts of the early inhabitants to the most recent sophisticated electronic equipment characteristic of the atomic and space age. Buckeye residents adjusted to the natural and increasingly man-made environment through the years slowly evolving their present complex, modern, dynamic, society. This statewide analysis of the study setting has revealed some of the environmental factors which play a vital part in shaping the lives of the people living and working in Ohio including disabled Ohioans.

B. Population Characteristics

1. Racio-Ethnic Composition

The Caucasoid European entered the Ohio scene as its predominately Algonkin native population was trying to stem the advance of another Amerind Group, the more intensely organized Iroquois. This white influx took place about four centuries ago. French and British invasion, followed by prolonged warfare, displaced many of the original peoples to the lands west of Ohio. Those native people who remained and survived played minor roles in the subsequent rapid expansion of activities; namely agriculture, manufacturing, and commerce, in the area destined to become the State of Ohio.

The population flow, primarily from and through states to the East, included immigrants from Germany, Scotland, Ireland, and England. Puritans, Moravians, Mennonities, Shakers, and Quakers added to the cultural mix already well diversified. As these different groups developed their settlements in accordance with their cultures, pronounced differences in speech, dress, customs and interests became apparent in spite of the blending and necessary adjustments in adapting to the demands of the Ohio way of life.

Entering through the southern portion of the Ohio landscape, Negro residents were numbered in the thousands in the early eighteen-hundreds. As time went on, this particular racial group tended to settle in urban areas such as Cincinnati, Cleveland, and Columbus, as opposed to the deep South were the Negro population remained principally in rural areas.

Currently, the influx of peoples to the Ohio scene would include substantial numbers from the bordering states of West Virginia, Kentucky, and Pennsylvania. Smaller incoming minorities, often on a temporary basis, would include Indians from India, and other foreign nationals, residing in areas where higher education is made available. Also, Puerto Ricans, and Texans of Mexican abstraction to date come into Ohio primarily as members of the migratory labor forces that work seasonal farm crops. Still another group of migrants, southern Negroes, originates and terminates in Florida .

TABLE 4

POPULATION BREAKDOWN - BY REGION - RACE and SEX - OHIO

MALE	Reg. I	Reg. II	Reg. III	Reg. IV	Reg. V	Reg. VI	Reg. VII
White	459,788	919,031	783,241	443,091	499,543	688,878	582,554
Negro	24,409	131,664	55,223	12,815	44,066	69,454	44,996
Indian	89	310	154	61	116	136	93
Japanese	70	672	93	22	121	189	148
Chinese	141	505	160	52	302	256	88
Filipino	32	190	63	18	67	84	46
Other	88	346	143	34	278	163	145
Total	484,617	1,052,718	839,077	456,093	544,493	759,160	628,070
FEMALE							
White	476,546	959,192	806,006	453,271	513,173	723,363	602,021
Negro	25,989	140,994	56,859	11,666	44,358	76,021	47,583
Indian	80	319	145	58	123	127	99
Japanese	92	721	170	68	247	272	250
Chinese	66	356	122	31	172	191	65
Filipino	34	155	50	15	66	81	43
Other	67	280	105	37	155	127	138
Total	502,874	1,102,017	863,457	465,146	558,294	800,182	650,199
ALL RACES							
Male	484,617	1,052,718	839,077	456,093	544,493	759,160	628,070
Female	502,874	1,102,017	863,457	465,146	558,294	800,182	650,199
Total	987,491	2,154,735	1,702,534	921,239	1,102,787	1,559,342	1,278,269

URBAN POPULATION

PERCENTAGE DISTRIBUTION BY COUNTIES

1960

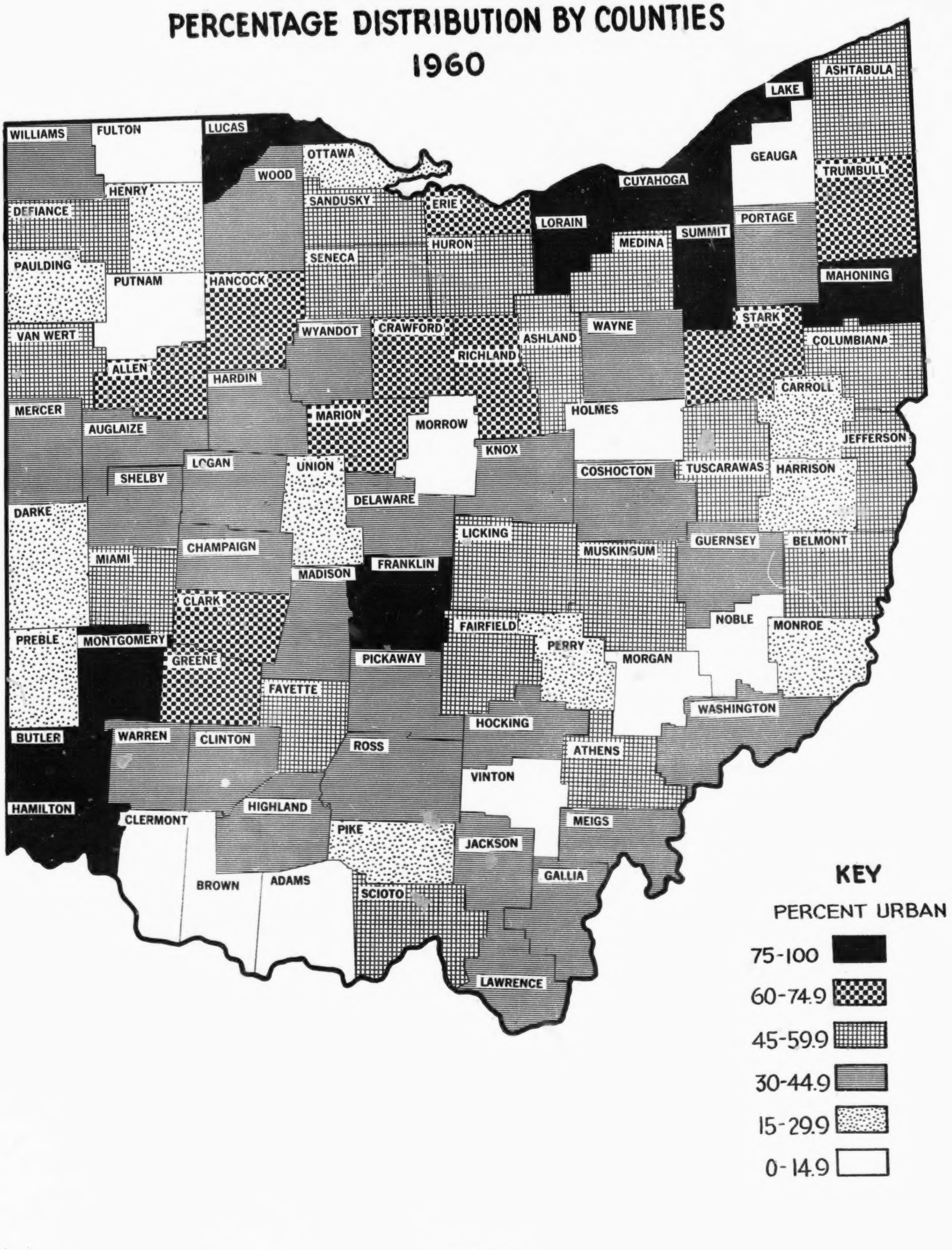
WILLIAMS
FULTON
LUCAS
OTTAWA
WOOD
HENRY
DEFIANCE
SANDUSKY
ERIE
LAKE
ASHTABULA
GEAUGA
TRUMBULL
CUYAHOGA
PORTAGE
LORAIN
MEDINA
SUMMIT
HURON
SENECA
PAULDING
PUTNAM
HANCOCK
MAHONING
STARK
COLUMBIANA
VAN WERT
ALLEN
WYANDOT
CRAWFORD
ASHLAND
WAYNE
RICHLAND
HARDIN
CARROLL
MERCER
AUGLAIZE
MARION
MORROW
HOLMES
KNOX
JEFFERSON
SHELBY
LOGAN
UNION
COSHOCTON
TUSCARAWAS
HARRISON
DELAWARE
DARKE
LICKING
CHAMPAIGN
MIAMI
MUSKINGUM
GUERNSEY
BELMONT
FRANKLIN
MADISON
CLARK
FAIRFIELD
NOBLE
MONROE
PREBLE
MONTGOMERY
PERRY
MORGAN
GREENE
PICKAWAY
FAYETTE
WASHINGTON
HOCKING
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
CLERMONT
HIGHLAND
MEIGS
PIKE
JACKSON
GALLIA
BROWN
ADAMS
SCIOTO
LAWRENCE
KEY
PERCENT URBAN
75-100 ■
60-74.9 ▩
45-59.9 ▦
30-44.9 ▤
15-29.9 ░
0-14.9 □

FIGURE 12

The Old World influence is rapidly declining in Ohio as fewer foreign born citizens enter, e.g. from Ireland or Germany, and as about-two thirds of residents of the state are now born here, and the foreign ethnic identifying characteristics are less in evidence each decade.

Emigrations from Ohio occurred first with the American Indians being pushed steadily westward, and later, when the earliest European pioneers also moved farther to the West as the influx of later successive waves of more permanent settlers from the East moved in. At the present time, with the exception of a reduction in the immigration from the East, and the immigration from the deep South, the most significant population trend is in the movement of Ohioans from the rural to the urban areas of the State.

The total of all this is that, as of 1960, the characteristics of the population of the State of Ohio were as set forth in TABLE 4. Figures 12, 13, and 17 give further population data.

2. State Distribution

The population of the state is not equally distributed. The density ranges from Cuyahoga County with its approximately 1,700,000 people living in a megalopolis complex on the southern shore of Lake Erie, a seaport and manufacturing center of international fame, to Vinton County in the Appalachian highlands of southern Ohio where some 9,700 inhabitants live. Each shares the area with about 25 others per square mile. Belmont, Miami, Scioto, Warren, Wayne, and Wood counties fall approximately between these two extremes and are widely scattered over the state. The population distribution in Ohio covers a wide range numerically and geographically. The density pattern tends to be related somewhat proportionately to the natural resources inherent in the location.

3. Urban Centers

While in recent years the population growth rate has not increased as rapidly as it has in the past, due to the decrease in birth and immigration rates, there has been a tendency for people to continue to concentrate thus increasing the popula-

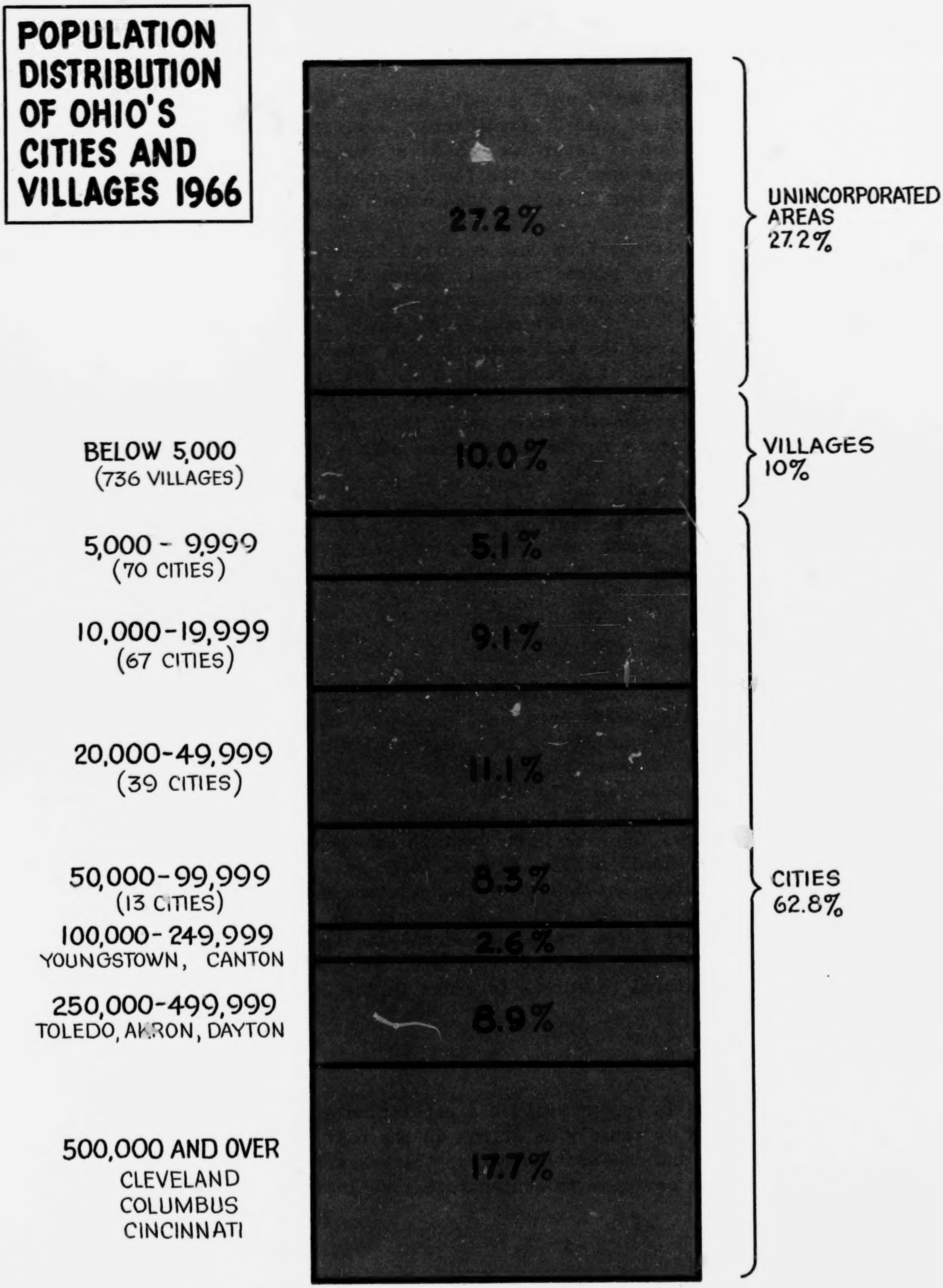
POPULATION DISTRIBUTION OF OHIO'S CITIES AND VILLAGES 1966
27.2%
UNINCORPORATED AREAS 27.2%
BELOW 5,000 (736 VILLAGES)
10.0%
VILLAGES 10%
5,000 - 9,999 (70 CITIES)
5.1%
10,000-19,999 (67 CITIES)
9.1%
20,000-49,999 (39 CITIES)
11.1%
50,000-99,999 (13 CITIES)
8.3%
100,000-249,999 YOUNGSTOWN, CANTON
2.6%
250,000-499,999 TOLEDO, AKRON, DAYTON
8.9%
500,000 AND OVER CLEVELAND COLUMBUS CINCINNATI
17.7%
CITIES 62.8%

FIGURE 13

tion in existing urban areas. The net interstate migration is also producing a slower growth rate as interstate migration appears to be reaching a point of equilibrium. With the expansion of relatively closely situated urban complexes and the resulting overlapping of spheres of influence and interaction, urban belts began to develop. In Ohio, these are located in the Akron-Cleveland-Youngstown portion of the state, in the Greater Toledo Area, in the Cincinnati-Dayton-Springfield Area, and in the center of the state around Columbus. Population tends to radiate from these centers following the routes of the new highway systems. This may, or may not, be the case, however, where the Ohio Interstate-Appalachian Highway crosses southern Ohio due to the rugged nature of the terrain and relative remoteness from most of the large industrial complexes.

4. Ohio Population Trends

Of the 10,700,000 people who will be living in Ohio in the year 1970, there will be, as compared to the 1960 census estimates, an expected 2.0 percent increase in the number of nonwhites. The percentage of native-born Ohioans will have increased by about 22.5 percent by that time with the greatest increases in the young and old segments of the population. Approximately 12.0 percent of the population of the state will have at least one disability, physical or mental. More typically, the average expected would be about 147 disabilities per 100 disabled persons. If the socially disadvantaged are included, the number of disabled in Ohio approximately doubles, and the overlapping of disabilities increases. The socially disabled would include the alcoholic, social offender, drug addict, and economically, socially, and culturally deprived people. It is with Ohio's disabled citizens that this Comprehensive Statewide Study concerned itself primarily.

Trends in the overall Ohio picture include among other things, a reduction in the number of people residing and working in rural farm areas, and an increase in the size of farms which proportionately will employ fewer persons per farm. Land conservation will of necessity be more widely practiced, and prescribed recreational uses of land will increase. Strip mining will increase and require considerable efforts to return the land to any usefulness. As it takes typically about 600 years to make an inch of top soil, obviously land reclamation will be a long range proposition. The production and use of

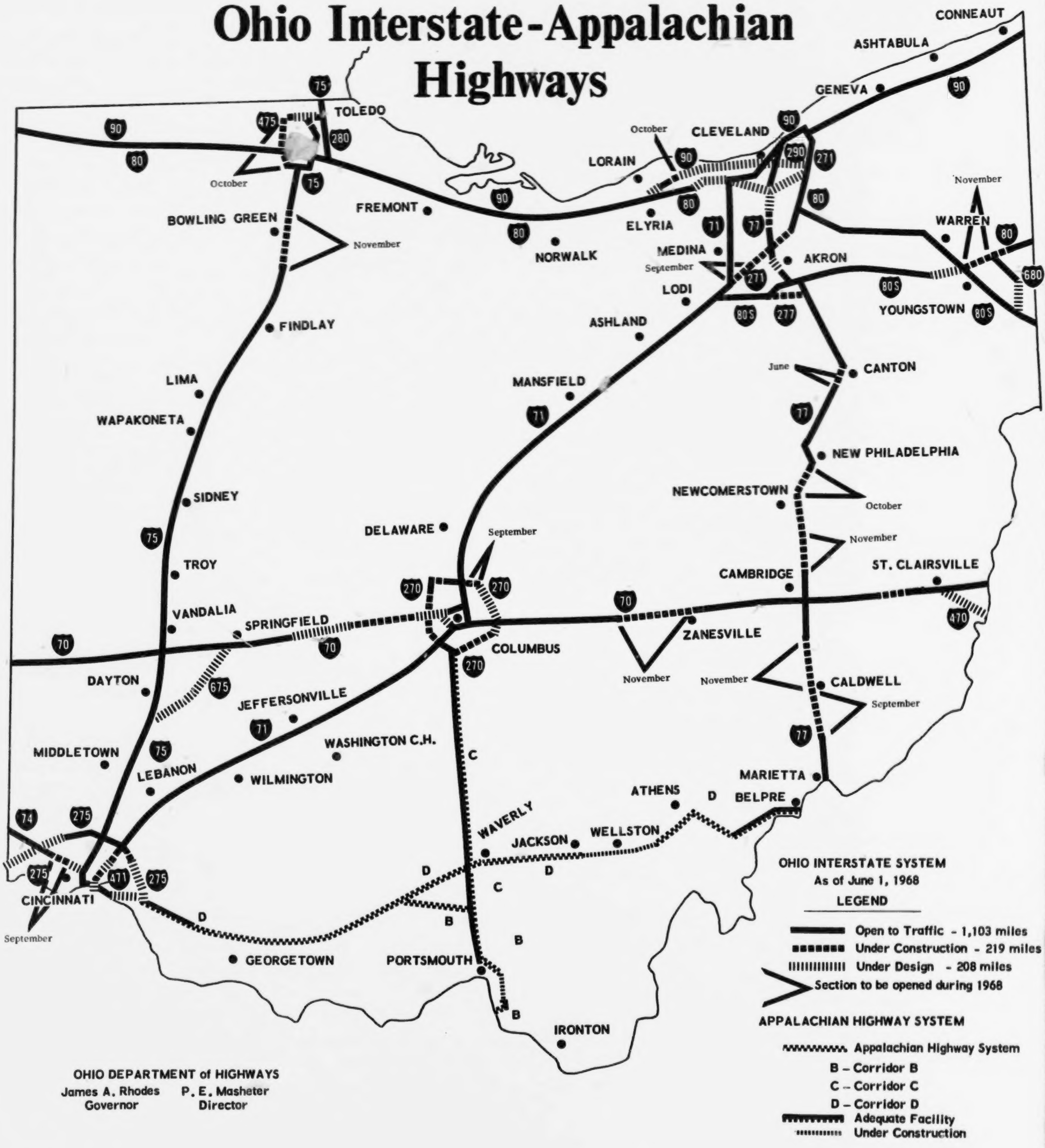
Ohio Interstate-Appalachian Highways
TOLEDO
CONNEAUT
ASHTABULA
GENEVA
CLEVELAND
LORAIN
ELYRIA
FREMONT
NORWALK
BOWLING GREEN
MEDINA
AKRON
LODI
WARREN
YOUNGSTOWN
ASHLAND
FINDLAY
CANTON
MANSFIELD
LIMA
WAPAKONETA
NEW PHILADELPHIA
NEWCOMERSTOWN
SIDNEY
DELAWARE
CAMBRIDGE
ST. CLAIRSVILLE
TROY
VANDALIA
SPRINGFIELD
ZANESVILLE
COLUMBUS
DAYTON
CALDWELL
JEFFERSONVILLE
WASHINGTON C.H.
MIDDLETOWN
LEBANON
WILMINGTON
MARIETTA
ATHENS
BELPRE
WAVERLY
JACKSON
WELLSTON
CINCINNATI
GEORGETOWN
PORTSMOUTH
IRONTON
October
November
September
June
90
80
75
475
280
290
271
71
77
80S
277
680
70
270
470
675
74
275
471
B
C
D
OHIO INTERSTATE SYSTEM
As of June 1, 1968
LEGEND
Open to Traffic - 1,103 miles
Under Construction - 219 miles
Under Design - 208 miles
Section to be opened during 1968
APPALACHIAN HIGHWAY SYSTEM
Appalachian Highway System
B – Corridor B
C – Corridor C
D – Corridor D
Adequate Facility
Under Construction
OHIO DEPARTMENT of HIGHWAYS
James A. Rhodes Governor
P. E. Masheter Director

FIGURE 14

coal will play a less important part in the lives of Ohioans.

C. Transportation

Ohio's roads cover the state, occupying about 565,000 of its acres, and forming a vast interlacing network totaling over 106,000 miles. The future growth of the state is intimately tied in with this system and the thousands of registered vehicles which depend on it.

Interstate highway systems are considered to be of prime interest to business concerns seeking new locations in which to build their plants. Some of the reasons for this include the increased accessibility to personnel, raw materials, expanded markets, and customers. A modern attractive plant visible from the interstate highway is good advertising for the company. With extimates showing that by 1975 Ohio motorists will drive more than 60 billion miles each year, with a substanital portion of the traffic being handled by the major arteries, the logic behind this trend to locate plants along these routes is readily understandable.

In 1966, tourists themselves added almost $2 billion dollars to the Ohio economy, and approximately $110 million dollars flow annually into the labor wages paid by highway contractors. Obviously, the Appalachia System will have a stimulating effect all along its route as it crosses the beautiful southern Ohio countryside.[1] The small towns in the area need this source of revenue.

D. Economic Characteristics

Table 5 gives an estimate of the average buying income per person in each county in Ohio. The figures were obtained by dividing the total effective buying income by the latest 1966 population figures for each county. The average buying income per person in Ohio is $1,964.00. The median is $2,067.00. The range was from $1,260.00 in Pike County to $2,874.00 in Cuyahoga County. See Figure 14.

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[1] Ohio Highway Progress - 1912-1967, Ohio Department of Highways, Bureau of Public Relations.

TABLE 5 AVERAGE BUYING INCOME BY COUNTY

RANK	COUNTY	*INCOME	RANK	COUNTY	*INCOME	RANK	COUNTY	*INCOME
1	Cuyahoga	$2874	30	Sandusky	$2108	59	Madison	$1815
2	Hamilton	2725	31	Lorain	2093	60	Pickaway	1806
3	Lucas	2589	32	Ottawa	2093	61	Logan	1805
4	Montgomery	2564	33	Seneca	2072	62	Union	1801
5	Franklin	2544	34	Knox	2036	63	Preble	1795
6	Summit	2522	35	Wayne	2036	64	Shelby	1794
7	Richland	2407	36	Ashtabula	2035	65	Fayette	1781
8	Butler	2355	37	Muskingum	2000	66	Harrison	1776
9	Stark	2312	38	Tuscarawas	1990	67	Scioto	1748
10	Erie	2822	39	Huron	1988	68	Hardin	1748
11	Geauga	2279	40	Champaign	1986	69	Paulding	1746
12	Hancock	2277	41	Defiance	1979	70	Gallia	1774
13	Miami	2277	42	Fulton	1972	71	Clermont	1740
14	Trumbull	2276	43	Medina	1963	72	Carroll	1694
15	Mahoning	2238	44	Clinton	1951	73	Washington	1690
16	Greene	2229	45	Ross	1950	74	Morgan	1668
17	Lake	2227	46	Coshocton	1949	75	Monroe	1638
18	Crawford	2214	47	Williams	1937	76	Lawrence	1625
19	Ashland	2211	48	Darke	1913	77	Highland	1623
20	Wood	2206	49	Belmont	1894	78	Hocking	1608
21	Clark	2201	50	Van Wert	1893	79	Perry	1588
22	Athens	2179	51	Warren	1877	80	Noble	1585
23	Jefferson	2175	52	Henry	1867	81	Putnam	1560
24	Marion	2171	53	Auglaize	1859	82	Jackson	1515
25	Licking	2171	54	Wyandot	1858	83	Brown	1457
26	Fairfield	2166	55	Columbiana	1844	84	Meigs	1406
27	Allen	2132	56	Mercer	1839	85	Holmes	1403
28	Delaware	2129	57	Guernsey	1830	86	Vinton	1378
29	Portage	2108	58	Morrow	1817	87	Adams	1325
						88	Pike	1260

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* INCOME = per person after taxes

COMPARATIVE BUYING POWER BY COUNTIES

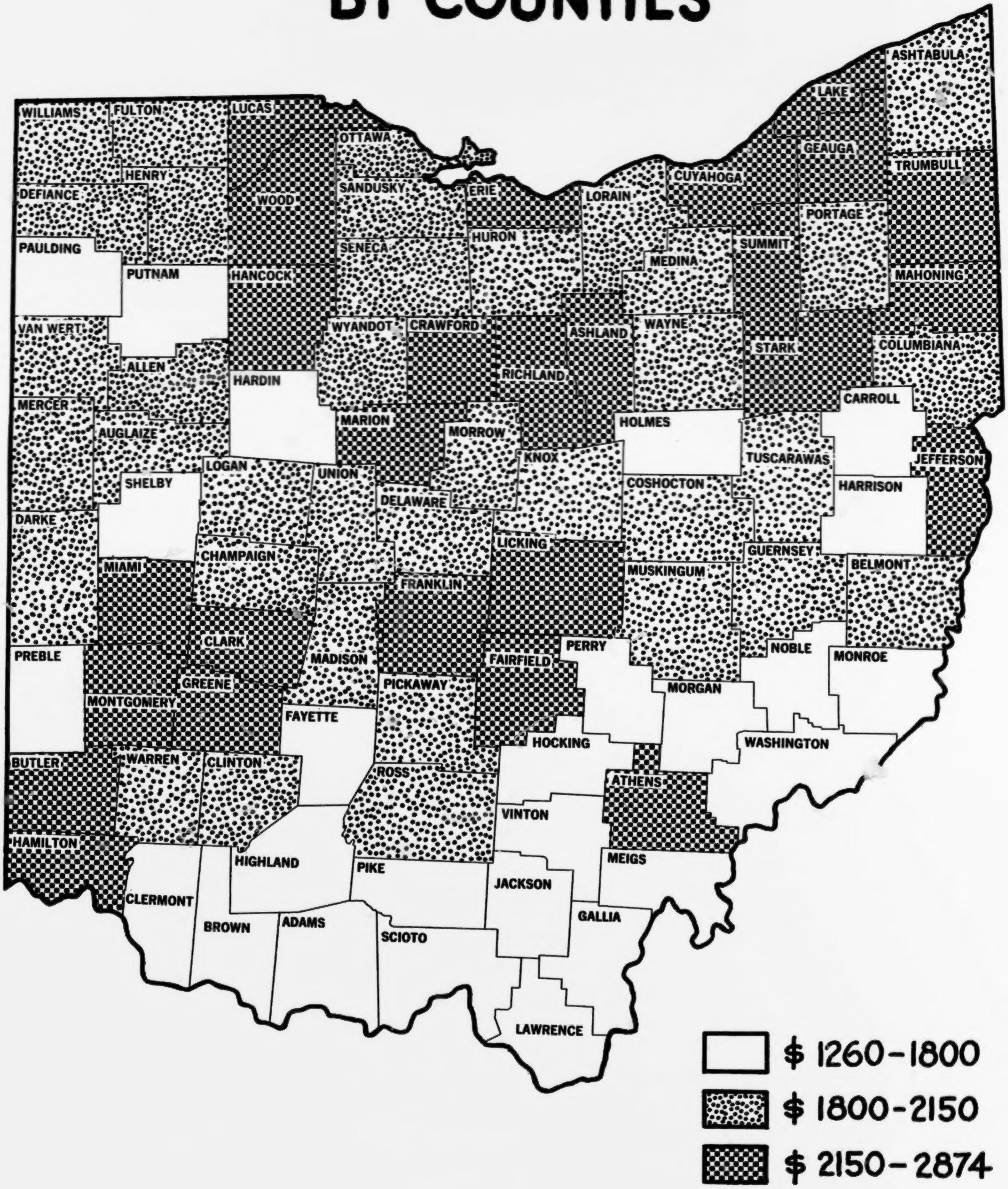

ASHTABULA
LAKE
WILLIAMS
FULTON
LUCAS
OTTAWA
GEAUGA
TRUMBULL
HENRY
CUYAHOGA
DEFIANCE
WOOD
SANDUSKY
ERIE
LORAIN
PORTAGE
PAULDING
SENECA
HURON
SUMMIT
MEDINA
PUTNAM
HANCOCK
MAHONING
VAN WERT
WYANDOT
CRAWFORD
ASHLAND
WAYNE
STARK
COLUMBIANA
ALLEN
RICHLAND
HARDIN
CARROLL
MERCER
MARION
MORROW
HOLMES
AUGLAIZE
KNOX
TUSCARAWAS
JEFFERSON
LOGAN
UNION
SHELBY
COSHOCTON
HARRISON
DELAWARE
DARKE
LICKING
GUERNSEY
CHAMPAIGN
MIAMI
BELMONT
MUSKINGUM
FRANKLIN
CLARK
PERRY
NOBLE
MONROE
MADISON
FAIRFIELD
PREBLE
GREENE
PICKAWAY
MORGAN
MONTGOMERY
FAYETTE
HOCKING
WASHINGTON
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
HIGHLAND
PIKE
MEIGS
JACKSON
CLERMONT
GALLIA
BROWN
ADAMS
SCIOTO
LAWRENCE
☐ $ 1260-1800
▨ $ 1800-2150
▩ $ 2150-2874

FIGURE 15

TABLE 6

Growth of Population, Per Capita Income, and State Funds: 1965-1967

State or Territory	Population (in 000's)				Per Capita Income Average				Growth in State Funds[5]	
	1965 Program[1]	1967 Program[2]	Per Cent Increase	Rank	1965 Program[3]	1967 Program[4]	Per Cent Increase	Rank	Per Cent Increase	Rank
Total	194,012	198,654	2%	-	$2,214	$2,362	7%	-	32%	-
Region I										
Connecticut	2,766	2,875	4	11	2,832	3,072	8	16	51	15
Maine	989	983	-1	49	1,835	1,945	6	33	45	20
Massachusetts	5.338	5,383	1	39	2,513	2,750	9	12	0[7]	52
New Hampshire	654	681	4	10	2,068	2,238	8	20	29	33
Rhode Island	914	898	-2	52	2,194	2,355	7	24	49	17
Vermont	409	405	-1	50	1,859	2,040	10	9	65	8
Region II										
Delaware	491	512	4	[illegible]	2,989	3,153	5	38	19[6]	37
New Jersey	6,682	6,898	3	17	2,655	2,836	7	27	1	50
New York	17,915	18,258	2	28	2,783	2,924	5	44	0[7]	53
Pennsylvania	11,459	11,582	1	36	2,238	2,369	6	34	17	39
Region III										
Dist. of Columbia	808	808	0	43	3,007	3,182	6	35	36[6]	27
Kentucky	3,159	3,183	1	37	1,557	1,713	10	8	33	29
Maryland	3,432	3,613	5	5	2,400	2,652	11	3	46	18
North Carolina ...	4,852	5,000	3	19	1,566	1,727	10	5	31	30
Puerto Rico	2,577	2,668	4	14	-	-	-	-	37	26
Virginia	4,378	4,507	3	20	1,851	1,973	7	30	58	13
Virgin Islands ...	35	50	43	1	-	-	-	-	74	3
West Virginia	1,797	1,794	0	45	1,664	1,802	8	18	37	25
Region IV										
Alabama	3,407	3,517	3	18	1,459	1,566	7	25	62	10
Florida	5,705	5,941	4	9	1,963	2,048	4	47	71	5
Georgia	4,294	4,459	4	13	1,606	1,752	9	13	55	14
Mississippi	2,314	2,327	1	41	1,183	1,305	10	4	200	1
South Carolina ...	2,555	2,586	1	33	1,379	1,519	10	6	72	4
Tennessee	3,798	3,883	2	24	1,549	1,699	10	10	58	12
Region V										
Illinois	10,489	10,722	2	25	2,624	2,844	8	17	5	46
Indiana	4,825	4,918	2	27	2,168	2,359	9	15	5	47
Michigan	8,098	8,374	3	16	2,279	2,402	5	40	41	22
Ohio	10,100	10,305	2	26	2,316	2,406	4	49	10	42
Wisconsin	4,107	4,161	1	32	2,158	2,301	7	29	69	6
Region VI										
Iowa	2,756	2,747	0	47	2,038	2,193	8	21	62	11
Kansas	2,225	2,250	1	35	2,062	2,204	7	26	3	49
Minnesota	3,521	3,576	2	30	2,067	2,237	8	19	18	38
Missouri	4,409	4,508	2	23	2,204	2,400	9	14	28	34
Nebraska	1,480	1,456	-2	51	2,098	2,256	8	22	65	9
North Dakota	645	650	1	40	1,626	1,937	19	1	38	24
South Dakota	715	682	-5	54	1,747	1,912	9	11	24	36
Region VII										
Arkansas	1,933	1,955	1	34	1,370	1,522	11	2	49	16
Louisiana	3,468	3,603	4	12	1,613	1,698	5	41	91	2
New Mexico	1,008	1,022	1	31	1,811	1,877	4	50	40	23
Oklahoma	2,465	2,458	0	46	1,835	1,915	4	46	30	31
Texas	10,397	10,752	3	15	1,944	2,020	4	48	68	7
Region VIII										
Colorado	1,966	1,977	1	38	2,300	2,420	5	43	0[7]	51
Idaho	692	694	0	42	1,787	1,885	5	39	30	32
Montana	705	702	0	48	1,988	2,119	7	31	17	40
Utah	992	1,008	2	29	1,923	2,054	7	28	45	21
Wyoming	343	329	-4	53	2,261	2,398	6	32	0[7]	54
Region IX										
Alaska	250	272	9	4	2,661	2,747	3	51	9[6]	43
Arizona	1,581	1,618	2	22	2,011	2,110	5	45	8	44
California	18,084	18,918	5	6	2,724	2,882	6	36	33	28
Guam	66	79	20	2	-	-	-	-	45	19
Hawaii	701	718	2	21	2,278	2,405	6	37	8	45
Nevada	408	454	11	3	2,850	3,138	10	7	26[6]	35
Oregon	1,871	1,955	4	7	2,233	2,398	7	23	14	41
Washington	2,984	2,980	0	44	2,314	2,435	5	42	3	48

[1] Population as of July 1, 1964

[2] Population as of July 1, 1966

[3] Average for 1959, 1960, 1961

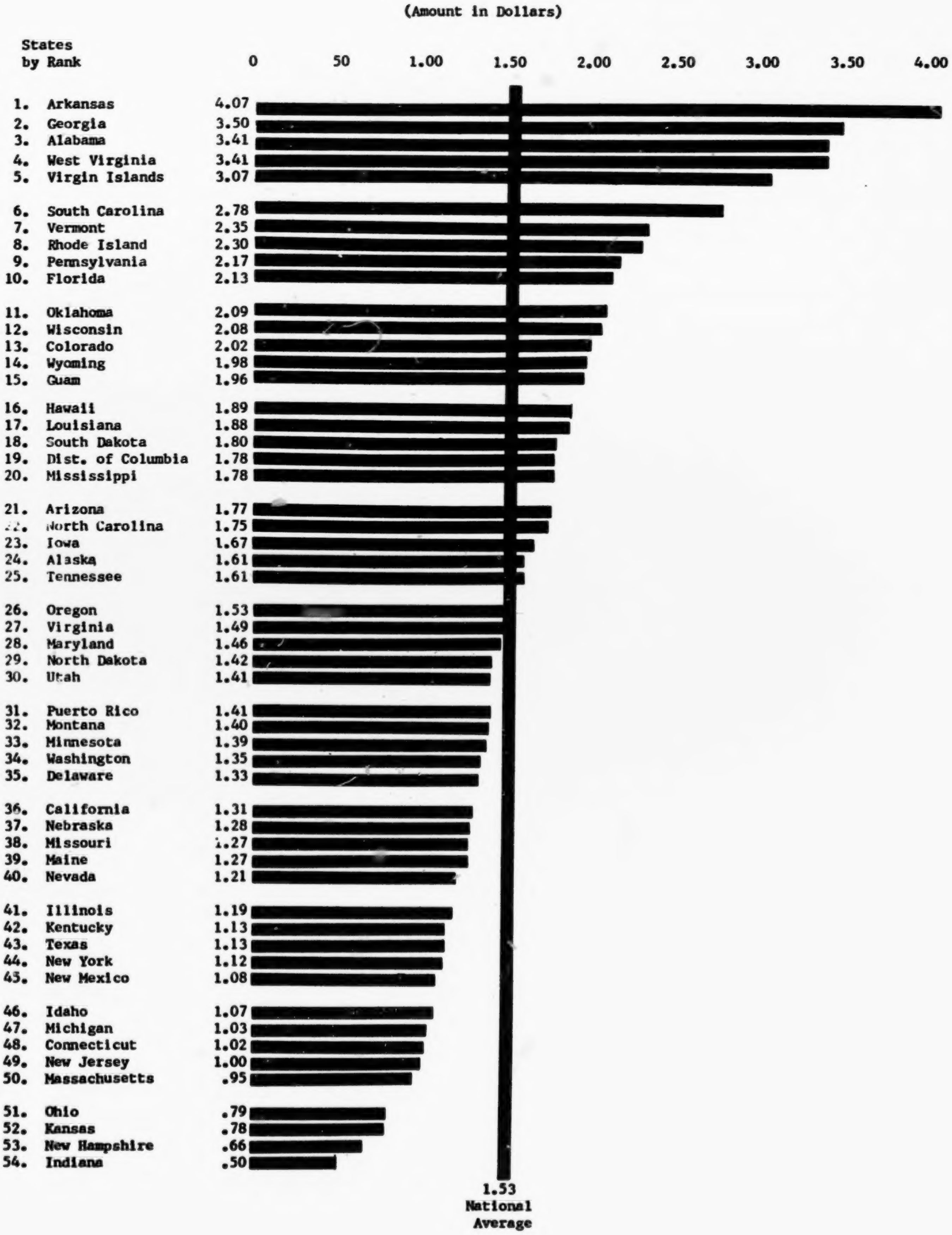
[4] Average for 1961, 1962, 1963

[5] Under Section 2 (including funds spent in excess of those required to earn full allotment)

[6] State spent funds in excess of those required to earn full allotment

[7] Required to maintain 1965 level of State expenditures

FIGURE 16
Per Capita Expenditures for Vocational Rehabilitation in 1967
(Federal and State Funds)



OHIOANS IN NEED OF REHABILITATION SERVICES

A. Estimates of Prevalence of Disability

Assembling the information needed to determine the nature and extent of disabling conditions in Ohio necessitated the use of a great many different sources of information. In order to facilitate Task Force activity in the seven Regions of the state, bench mark data was developed incorporating BVR categories of disability and applied across the board as an attempt to zero in on the problem. Basic findings of the National Health Survey were used for this purpose. Later, Task Force surveys, Telephone Survey/Counselor Follow-Up data and findings of other statewide planning in neighboring states were included. What evolved as the study progressed is presented in this section with the following concept in mind. While many issues and data are not crystalized at this time, a presentation of all sides of the picture--the sources of information, the rationale for the conclusions, and the different ways in which the problem can be approached--will enable future rehabilitation planning to build upon what has been begun in this two years of data gathering and assimilation. In this way, the material presented here should eliminate considerable duplication of effort in the rehabilitation field. This section is intended to augment and enrich statewide the work covered in the seven Regional Reports.

Disabilities can be classified in many ways. One method would be by the cause as illustrated by TABLE 7.

TABLE 7

MAIN CAUSES OF DISABILITY[1]

1.	Chronic Disease	88%
2.	Work Accidents	5%
3.	Home, Highway, Other Accidents	5%
4.	Congenital Conditions	2%
	TOTAL	100%

While for some groups classification by the etiological factor (such as a microorganism) or by the pathology involved is the most workable, for rehabilitation, the disabilities are classified according to a system uniquely advantageous to the discipline.

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[1] W. Scott Allan, "Community Effort--The Key to Successful Rehabilitation" (address delivered to the Ohio Rehabilitation Association meeting in Columbus, Ohio, 1960).

TABLE 8

DISABILITIES LIST ACCORDING TO BUREAU OF VOCATIONAL REHABILITATION CODE

CODE	Disability Group	CODE	Disability Group
10-11	Blind (legally)	53	Mental Retardation
12-14	Visual Impairments (other than legally blind)	60	Neoplasms
20-22	Deafness (all acoustical disabilities)	61	Allegeries - Endocrine - Nutritional - Metabolic
30-39	Orthopedics - MS, CP, MD, Similar Related Impairments	62	Blood-Vascular
40-44	Absence & Amputations (Major & Minor members)	63	Epilepsy-Neurological
50	Mental (Psychotic)	64	Cardiac
51	Psychoneurotic	65	Respiratory
52	Personality Disorders - Alcoholism - Drug Addiction - Social Offenders	66	Digestive
		67	Genito-Urinary
		68	Speech Impairment
		69	Not elsewhere classified (NEC)

In order to permit more meaningful examination of some of the more useful data relating to the prevalence of disabilities (data from other bench mark studies, as well as some locally devised and conducted surveys) the various groupings of pathological conditions were adjusted to fit the BVR disability two-digit code.

The two digit code identifies the major groupings of disabilities as recorded and reported by state and federal vocational rehabilitation organizations. The BVR disability coding system is set forth in detail in APPENDIX I for more detailed reference. By using the BVR categories for constructing cells, direct comparison with all other states and national organizations also using these categories and with most vocational rehabilitation figures was made possible. For this reason, most of the Ohio Statewide Planning for Vocational Rehabilitation study groups elected to follow this system rather than some other less related to actual BVR operations and records.

Many more useful comparisons were made available by this attempt to regroup and thus form equatable combinations. Also, as the number of clients handled by BVR and classified as Type 1 "Closed Rehabilitated", Type 2 "Closed Not Rehabilitated (after service)", Type 3 "Closed Not

Rehabilitated (before service)", and Type 4 "Never Eligible", are reported by the BVR breakdown in terms of these categories, a more uniform base on which to compare available BVR data was derived.

Some of the studies which were adjusted to fit this pattern included the National Health Survey, the West Virginia random sample to determine Incidence and Prevalence conducted as one facet of the Statewide Study for Vocational Rehabilitation in that state, data from the National Health Study which related to the prevalence of severe and chronic activity limitation, and STUDY OF HANDICAPPED IN MORROW COUNTY - (Ohio) conducted in 1963.[1] This last study relates most closely to the findings of the National Health Study section covering those with the more severe and chronic activity limitation.

TABLE 9 relates the adjusted NHS severe activity limitation data to the Study of the Handicapped in Morrow County, Ohio, also adjusted to conform to the BVR disability two digit code. Typically, these studies refer to the physically and mentally disabling conditions only.

In the NHS, the disabled population is considered to be approximately 12% of the population at large. Percentages given in the table are not percentages of the entire population, but percentages of the disabled population. For example, the visually handicapped and legally blind at 13.0% means 13% of the disabled, or 13% of 12% of the total population.

The NHS does not include institutionalized populations. The OHIO SCHOOL CENSUS, on the other hand, is not based on a breakdown of the disabled population, but rather of the general school age segment which constitutes about 21 percent of the total population numerically. This school survey permits some insights into the disabilities of this special age group. As no one study includes all the discrete disabilities and quantifies them, a disability that does not appear in one study might have been selected for analysis in another study.

There is no one comprehensive reference source for vocational rehabilitation disability prevalence data at this time. Information has to be pieced together from many sources. With this approach to filling in the gaps, the following adjusted compilations were developed as a means to establish the best estimates of the prevalence of these particular disabilities in which state and federal vocational rehabilitation organizations have a special interest, and which estimates zero in on a reasonable, identifiable area on a rather broad and complex spectrum.

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[1] Morrow County Study Formula:
Disabled Population = 1.9 Percent of Total Population; thus,
Visually Disabled = (.062) x (.019) x (20,681).

TABLE 9

ESTIMATING THE SEVERELY DISABLED POPULATION IN MORROW COUNTY (OHIO)

Morrow County Population = 20681. (1-Jan-66)

BVR Category	Morrow County Study (1963)		National Health Survey[2]	
	%	No.	%	No.
10-11				
12-14	6.2	24.	13.0	59.
20-22	6.9	27.	4.5	20.
30-39	35.6	139.	28.7	176.
40-44	5.4	21.	----	----
50	----	----		
51	----	----		
52	----	----	10.3	46.
53	----	----		
60	----	----	3.9	17.
61	2.6	10.	8.5	17.
62	----	----	14.0	63.
63	3.9	15.	----	----
64	16.2	63.	24.4	111.
65	6.2	24.	6.8	30
66	----	----	11.6	52.
67	----	----	5.7	25.
68	3.1	12.	----	----

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[1] Morrow County Study:
Disabled Population = 1.9 Percent of Total Population;
Visually Disabled = (.062) x (.019 x (20681.).

[2] National Health Study (Those Unable to Carry on Major Activity):
Disabled Population = 2.2 Percent of Total Population;
Visually Disabled = (.130) x (.022) x (20681.).

In relation to the other disabilities set forth, this area indicates a numerical relationship which can be further refined and delineated by additional study of related pertinent information from the many contributing sources. Discreetly used, these bench marks are useful working estimates. They permit comparisons and force the quantitative approach, an essential basis for planning. TABLE 10 presents a reference grid set up in this manner forcing the known information into a form permitting further insight into relationships between studies not otherwise discernable.

TABLE 10

PERCENTAGE ESTIMATES OF DISABILITY PREVALENCE ADJUSTED TO BVR CATEGORIES

BVR Category	(1) National Health Survey	(2) W.Va. Random Sample Results	(3) Ohio School Census
	%	%	%
10-11		1.0	0.1
12-14	5.5	6.7	
20-22	2.2	3.7	1.0
30-39	37.6	27.9	0.2
40-44	----	2.9	
50	7.7	5.0	5.0
51			
52			
53		4.6	4.0
60	2.2		---
61	7.4	9.4	---
62	13.5	1.0	---
63	----	2.5	10.0
64	16.0	18.6	----
65	5.6	7.4	----
66	9.7	3.1	----
67	5.0	2.4	----
68	----	0.7	5.0
69	----	4.1	----

LEGEND

(1) Converted to BVR categories and related to the disabled population at 12% of the total population of Ohio.

(2) W. Va. sample was based on BVR categories and the percentage breakdown of the disabled population estimated at 14% of the total population of that state.

(3) Ohio School Census - Percentages based on total school age population which comprises about 21% of the state population of Ohio which the survey was to cover.

This method of study revealed much invaluable date for Comprehensive Statewide Planning. For example, TABLE 11 presents an estimation of the potential number in selected disability groups in terms of the need for orthotic services. TABLE 12 is a breakdown of part of the data collected in the Ohio Telephone Survey.

TABLE 11

Estimated Incidence of Conditions
Potentially Requiring Orthotics
for the State of Ohio, 1970[1]

	Percent of Population	Number
Spastic paralysis:		
Hemiplegia	1.09%	116,000
Quadrilateral spastic paralysis:		
Cerebral palsy cases	.05%	5,000
Other spastic conditions	.27%	29,000
Flaccid: polios & Guillain-Barre		
(with one or both arms involved)	.05%	5,000
(very severely involved in one or both arms)	.01%	1,000
Comparable flaccid paralyses:		
Peripheral nerve lesions	.27%	29,000
Quadrilateral quadriplegia from cervical (C-5 or C06) lesions	.01%	1,000
Arthritis	6.01%	640,000
With rheumatoid deformities, most including some upper extremity involvement	2.18%	233,000
Myopathies, muscular dystrophy	.14%	15,000

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[1] Conference on Orthotics Research Development — Upper Extremity Orthotics, "Conditions Potentially Requiring Orthotics (Estimate Incidence in the United States)," OALMA Almanac (Washington, D.C.: October, 1959).

TABLE 12

BREAKDOWN of DISABLED INDIVIDUALS IDENTIFIED
by the
TELEPHONE SURVEY/COUNSELOR FOLLOW-UP

PROFILE INFORMATION OF 126 DISABLED PERSONS INTERVIEWED

I.	Not eligible for V. R. Services	82 out of 126	65.1%
II.	Deemed eligible/feasible	44 out of 126	34.9%

a.	Eligible/feasible and interested	17-23 out of 44	45.5%
b.	Eligible/feasible but disinterested	25 out of 44	56.8%

1.	Presently on welfare	3 out of 25	12%
2.	Never on welfare	21 out of 25	84%

a.	Economically Deprived	3 out of 21	14.2%
b.	Severely handicapped	2 out of 21	9.5%
c.	Over 65	1 out of 21	4.8%
d.	21 - 64	18 out of 21	85.7%
e.	14 - 20	1 out of 21	4.8%

f. MAJOR DISABILITIES LISTED

Orthopedic & functional disorders	8 out of 21	38.1%
Diabetic disorders	3 out of 21	14.2%
Endocrine disorders	3 out of 21	14.2%
Cardiac & circulatory disorders	2 out of 21	9.5%
Diseases & conditions of skin	2 out of 21	9.5%
Respiratory disorders	2 out of 21	9.5%
Speech impairment	1 out of 21	4.8%

TABLE 12 (Continued)

DISABILITY DATA FROM THE COUNSELOR FOLLOW-UP OF THE TELEPHONE SURVEY (126 DISABLED PERSONS SURVEYED)

I. Overall level of disability

Number of People	Level of disability as determined by counselor
39	None
21	Slight
15	Mild
19	Moderate
19	Severe
12	Very Severe

II. Frequencies of disabilities

Disability	Percentage of 126 persons who listed this as a primary disability	Percentage of 126 persons who listed this as a secondary disability	Percentage of 126 persons who listed this as a third disability
No Disability	7.8%	59.4%	83.6%
Blind - Both Eyes	0.0%	0.0%	0.0%
Other Visual Impairment	5.5%	1.6%	1.6%
Congential Malformation	0.8%	0.0%	0.0%
Arthritis and Rheumatism	5.5%	8.6%	1.6%
Poliomyelitis	0.8%	0.8%	0.0%
Stroke	2.3%	0.8%	0.0%
Other Orthopedic Condition	12.5%	5.5%	2.3%
Epilepsy	1.6%	0.0%	0.8%
Absence or Amputation	0.8%	0.0%	0.0%
Mental Retardation	3.1%	0.0%	0.0%
Psychotic & Psychoneurotic	5.5%	0.8%	0.8%
Cancer	0.8%	0.0%	0.0%
Hay Fever and Asthma	7.0%	1.6%	0.8%
Other Allergies	0.8%	1.6%	0.0%
Diabetes	6.3%	3.1%	2.3%
Endocrine	3.9%	1.6%	0.0%
Disease of Blood	1.6%	3.1%	0.8%
General Cardiac	12.5%	0.0%	0.0%
Rheumatic Fever	2.3%	0.8%	0.0%

TABLE 12 (Continued)

	Percentage of 126 persons who listed this as a primary disability	Percentage of 126 persons who listed this as a secondary disability	Percentage of 126 persons who listed this as a third disability
Hypertensive Heart Disease	3.9%	3.9%	1.6%
Emphysema	1.6%	0.0%	0.8%
Bronchiectasis	5.5%	3.9%	0.8%
Disease of Respiratory System	1.6%	0.0%	0.0%
Speech impairment	1.6%	0.0%	0.0%
Diseases of Skin	2.3%	0.0%	0.0%
Ulcer	0.8%	1.6%	0.8%
Genito-Urinary	0.8%	0.0%	0.0%
Chronic Enteritis & Ulcerative Colitis and Hernia	0.0%	0.0%	0.8%
Other Conditions of Digestive System	0.0%	0.8%	1.6%

III. Weekly Earnings

Weekly Earnings	Percentage of 126 Interviewed Earning this Amount
$ 00 - 09	69.5%
10 - 100	18.7%
100 - 200	8.7%
200 - 300	2.4%
300 - 400	0.8%

TABLE 13

Prevalence of Disabilities Per 1,000 Population Using Collapsed Disability Code (Results from Telephone Interviews)

	Regional Average*	Ohio
Orthopedic & Functional Impairment	105.37	87.5
Diabetes	15.42	16.8
Visual Impairment	13.70	14.5
Hearing & Speech Impairment	14.97	11.64
Cardiac & Circulatory Disorders	63.06	53.85
Respiratory Disorders	52.03	50.0
Mental & Personality Disorders	29.14	28.1
Mental Retardation	1.54	2.3
Other	95.31	79.3

* Federal Region Five includes Illinois, Indiana, Michigan, Ohio, and Wisconsin, plus the addition of Minnesota in this study.

In the fall of 1967, and winter of 1968, working in conjunction with the Regional Research Institute, Madison, Wisconsin, a uniform survey designed to evaluate rehabilitation need was conducted in the states of Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. A copy of this study will be found in APPENDIX VI for reference. The findings of this Telephone Survey are to be found in APPENDIX III . For the State of Ohio, the prevalence of disabilities per 1,000 population, estimated by this study, refers to the potential BVR clientele in the state; namely, those in the 14-70 year old age group. TABLE 13 sets forth these findings in brief.

The rehabilitation counselor follow-up on the households reporting one or more disabled persons living there adds insight not hithertofore available in that it evaluates the disabled person concerning the apparent feasibility of rehabilitating this person and, therefore, indicates whether or not, in the opinion of the professional vocational rehabilitation counselor, this particular person would appear eligible for vocational rehabilitation services. It also records the disabled person's interest (motivation) toward applying for, and cooperating in, a planned program for his vocational rehabilitation (See Table 11). In Ohio, a screening random sampling involving 2,000 contacts resulted in 183 disabled persons being identified and interviewed. Subsequent counselor follow-up brought out information on the disabled people in the 14-70 age group.

An idea of what a breakdown of the Ohio population (1975 population estimate) would look like by disability categories as set up by the Regional Rehabilitation Research Institute, Madison, Wisconsin, for the compilation of data from the Telephone Survey/Counselor Follow-Up has been placed in APPENDIX IV.

Estimates of rates of prevalence of approximately fifty disability categories resulting from the Telephone Survey/Counselor Follow-Up project are presented in TABLE 14. To permit comparison, the regional average of the states participating in this study is presented with the Ohio data. TABLE 15 relates the results of this survey to the Ohio scene in terms of estimated numbers.

TABLE 14

PREVALENCE OF DISABILITIES PER 1,000 POPULATION
(Results from Telephone Interviews)

Disability	Regional* Average	Ohio	
Blindness in both eyes	0.73	0.32	
Other visual impairments	12.97	14.20	
Deafness	2.20	1.60	
Other hearing impairments	10.23	8.10	
(Congenital malformation	2.24	0.97)	
(Arthritis & rheumatism	30.48	27.80)	31.32
(Poliomyelitis	1.28	0.65)	
(Stroke	3.23	1.90)	
Other orthopedic conditions	57.57	42.60	
Epilepsy	1.96	3.20	
Cerebral Palsy	0.45	0.65	
Muscular Dystrophy	0.07	0.00	
Multiple sclerosis	0.45	0.32	
Parkinson's disease	0.35	0.65	
Other disorders of the nervous system	3.36	3.60	
Amputation of upper extremity	1.51	2.90	
Amputation of lower extremity	0.79	1.30	
Amputation of upper & lower extremity	0.00	0.00	
Psychotic & psychoneurotic disorders — mental illness, nervousness	27.64	26.50	
Alcoholism	1.50	1.60	
Drug addiction	0.00	0.00	
Mental retardation	1.54	2.30	
Cancer	4.08	1.90	
Hayfever & asthma	22.07	18.40	
Other allergies	16.50	13.60	
Diabetes	15.42	16.80	
Other endocrine disorders	19.34	18.40	
Diseases of the blood & blood-forming organs	4.84	2.60	
General cardiac & circulatory conditions, NFS	21.45	25.80	
Congenital heart disease	0.27	0.00	

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* Federal Region Five includes Illinois, Indiana, Michigan, Ohio, and Wisconsin, plus the addition of Minnesota in this study.

TABLE 14 (Continued)

DISABILITY	Regional* Average	Ohio
Rheumatic fever & chronic heart condition	3.75	3.20
Arteriosclerotic & degenerative heart disease	1.16	0.65
Hypertensive heart disease	33.88	24.20
Varicose veins & hemorrhoids, phlebitis	2.55	1.30
Tuberculosis	0.82	0.65
Emphysema	3.47	4.20
Pneumoconiosis & asbestosis	0.15	0.32
Bronchiectasis	0.40	0.32
Chronic bronchitis & sinusitis	18.85	18.70
Diseases of the respiratory system, NFS	6.27	7.40
Conditions of teeth & supporting structures	0.65	0.00
Ulcer of stomach & duodenum	10.49	8.10
Chronic enteritis & ulcerative colitis and hernia	0.61	0.00
Colostomies, colitis	1.92	1.30
Other conditions of digestive system	9.79	7.80
Conditions of genito-urinary system	13.70	12.00
Cleft palate and/or harelip	0.28	0.32
Stammering & stuttering	1.37	0.32
Laryngectomies	0.03	0.00
Aphasia	0.00	0.00
Other speech impairments	0.86	1.30
Diseases & conditions of the skin	10.84	12.30
Paraplegia	0.24	0.00
Other, e.g., fainting spells	1.39	0.97

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* Federal Region V includes Illinois, Indiana, Michigan, Ohio, and Wisconsin, plus the addition of Minnesota in this study.

TABLE 15

DISABILITY PREVALENCE AS ESTIMATED FROM OHIO TELEPHONE SURVEY/COUNSELOR FOLLOW-UP 1967

Disability	Rate/1000	Estimated Number of Disabled in Ohio in 14-70 Age Group
Other Orthopedic Conditions . . .	42.6	310,000
Arthritis and Rheumatism	27.8	202,000
Psychotic and Psychoneurotic Disorders -- Mental Illness, Nervousness	26.5	193,000
General Cardiac and Circulatory Conditions, NFS	25.8	188,000
Hypertensive Heart Disease	24.2	176,000
Chronic Bronchitis & Sinusitis	18.7	136,000
Hayfever and Asthma	18.4	134,000
Other Endocrine Disorders	18.4	134,000
Diabetes	16.8	122,000
Other Visual Impairments	14.20	103,000
Other Allergies	13.6	99,000
Diseases and Conditions of Skin	12.3	90,000
Conditions of Genito-Urinary System	12.0	87,000
Other Hearing Impairments	8.1	59,000
Ulcer of Stomach & Duodenum	8.1	59,000
Other Conditions of Digestive System	7.8	56,000
Diseases of the Respiratory System	7.4	54,000
Emphysema	4.2	31,000
Blindness in Both Eyes	0.32	2,400
Arteriosclerotic and Degenerative Heart Disease	0.65	5,000
Multiple Sclerosis	0.32	2,300
Pneumoconiosis and Asbestosis	0.32	2,300
Bronchiectasis	0.32	2,300
Cleft Palate and/or Harelip	0.32	2,300
Stammering and Stuttering	0.32	2,300

One inference from the Telephone Survey/Counselor Follow-Up data in which about 23 percent of the 14-70 age group in Ohio reported disabilities is that for every 68 people, 100 disabilities are listed, and thus 23 percent of the 14-70 age group would point to 1,673,000 disabilities distributed among 1,138,000 people. If this ratio is applied to the total state population, which it was not, and is done here in lieu of this information, this would result in this group representing a potential BVR clientele constituting about 16 percent of the total state population and is roughly comparable to the 12 percent figure reported by the National Health Survey which is now generally believed to be low due to under-reporting.

Considering TABLE 14 the sum of the two orthopedically encompassing categories indicates that about 73.9 people per 1,000 of the 14-70 population could be expected to possess some form of orthopedically related disability and at the quantities indicated.

Third in position, as determined by rate per thousand individuals, is the group which includes the psychotic and psychoneurotic disorders--mental illness, nervousness (BVR codes 50-51-52). This category was determined by the Telephone Survey/Counselor Follow-Up to be at the rate of 26.5 per 1,000 in Ohio. Converted to actual estimated numbers in Ohio, this indicates approximately 284,000 individuals in the state who could reasonably be expected to be included in this disability category according to the results of this particular random sample. This group, as defined in this particular survey, includes individuals between the ages of 14 and 70 only, and, due to the design of the study, was intended to yield results that could be interpreted as a quantitative measure of the need for vocational rehabilitation services in the categories covered by the study.

Mental retardation, BVR code 53, is not included in this particular disability category concerning mental disabilities in this study as it has been in other studies, hence the mental retardation quantitative analysis and resulting relative categorical position is not included in the third position, but covered where it quantitatively fits the array of disabilities reported.

The fourth largest category resulting from the Telephone Survey includes the group of disabilities referred to as general cardiac and circulatory conditions. This disability group was determined to exist in the population sample at the rate of 25.8 per thousand, indicating approximately 276,000 cases in Ohio. When combined with the closely related hypertension heart disease at 24.2 per thousand, 259,000 in Ohio, the fifth largest grouping, this combination sums to an impressive 50 per thousand rate, 534,000 in Ohio, and is exceeded only by the combined orthopedic categories at 73.8 per thousand in the 14-70 age group.

Again, TABLE 15, and APPENDIX III, present a detailed breakdown of the findings resulting from the Telephone Survey/Counselor Follow-Up research project. In reference to this most recent attempt to quantitatively ascertain the nature and number of disabled people in Ohio and, thus, add to the data on which final estimations of the rehabilitation need may be derived, the following observations are reviewed.

B. Comparability of Data on Prevalence of Disability

The Closed Case Record, form VR-300, is one of the best sources of BVR data. The use of the BVR category adjusted prevalence rates from other sources permits direct comparison with information contained in the VR-300, and therefore makes relationships between other studies much more comparable than otherwise.

For example, this re-grouping to conform with BVR reporting permits direct comparison with Statewide Planning study data which may be expected to use the VR categories. APPENDIX I contains the VR-300 for reference. The disability involved in APPENDIX III is typically referred to in the BVR three digit code form. Specific examples of use of the BVR code situation would also include some of the analyses made by Harbridge House, Inc., of Boston. An example of the equatability of data from different states using the BVR code would be the random sample survey conducted in West Virginia in January, 1967, in conjunction with the statewide study of vocational rehabilitation which followed the BVR categories. Further research in this field is, of necessity, going to have to relate pragmatic and empirical data concerning rehabilitation to information forthcoming from other less diversified and interdisciplinary fields. Only by re-working the data to a form roughly comparable to BVR record keeping, such as the R-300, etc., can much use be made of findings in the fields of medicine, public health, and other allied medical publications. Rehabilitation is an applied art and science, and its informational needs will have to be met in large degree by studies not VR oriented as was the Telephone Survey/Counselor Follow-Up.

APPENDIX VI indicates how the West Virginia Statewide Comprehensive Planning Project Sample Survey data is readily comparable to other studies where the BVR categories are used directly, or indirectly, in reporting findings. It is relatively simple to apply findings such as these in West Virginia to Ohio counties just across the Ohio River in the Appalachian area in Ohio.

An example is Monroe County which, on an Ohio county rating scale of 1 to 88, based on per capita buying power, rates 85th, or near the low end of the scale. Number one is Cuyahoga County, which includes the city of Cleveland; Vinton County which, like Monroe, is also in Appalachia, ranks

TABLE 16

DISABILITY PREVALENCE BENCH MARKS FOR AN APPALACHIAN OHIO COUNTY

(Monroe County Population 15,507)
(1-Jan-66)

BVR Category	National Health Survey[1]		W.Va. Random Sample Results (January, 1967)[2]	
	%	No.	%	No.
10-11			1.0	21.
12-14	5.5	102.	5.7	123.
20-22	2.2	40.	3.7	80.
30-39	37.6	699.	27.9	605.
40-44	----	----	2.9	62.
50				
51			5.0	108.
52	7.7	143.		
53			4.6	99.
60	2.2	40.		
61	7.4	137.	9.4	204.
62	13.5	251.	1.0	21.
63	----	----	1.0	21.
64	16.0	297.	18.6	403.
65	5.6	104.	7.4	160.
66	9.7	180.	3.1	67.
67	5.0	93.	2.4	52.
68	----	----	0.7	15.
69	----	----	4.1	89.

---

[1] National Health Study (All degrees of activity limitation): Disabled Population = 12 percent of total population; Visually Disabled = (.055) x (.12) x (15507.).

[2] W.Va. Random Sample Results (All degrees of activity limitation): Disabled Population = 14 percent of total population; Legally Blind - (.010)x (.14) x (15507.).

88. (TABLE 5 presents a listing of the economic ranking of Ohio counties based on average buying income.)

TABLE 16 indicates the estimations that result from this approach. These figures, as in many studies, relate the percentages to the disabled population. In the case of the West Virginia study, this disabled population approximated 14.0 percent of the general population of the state. In the case of the National Health Study, the disabled population for the United States as a whole was estimated to be approximately 12.0 percent of the general population and applied to census data available at that time. The following table also relates Monroe County, Ohio, to the National Health Study by adjusting the disabilities to the categories used by state and federal vocational rehabilitation organizations. Such estimates permit tailoring existing available data to specific classifications thus providing some bench marks for reference until more specific information is made available. No one particular estimate is considered as the final word; however, when several estimates from different sources are plotted and the resulting calculations fall in approximately the same range, the chances are increased that the data is shedding light on what exists. In many instances, these relationships derived from varying sources may be the best information available for some time in the future. If used with discretion, they provide some numerical bench marks if not precise quantities.

Concerning observations from the preceeding table, the following elaborations may be helpful. BVR categories 10-11 concern themselves with the legally blind and as such, these are not handled in Ohio by the BVR, but rather are clients of the Bureau of Services for the Blind, a subdivision of the Department of Public Welfare. Categories 12-14 include all visual disabilities excluding those found in people who have been determined to be legally blind. Many studies, such as the National Health Study, put 10-11 and 12-14, or all visual disabilities, into one category. In this instance it is necessary to refer to a random sample such as the one conducted for statewide planning in West Virginia[1] since in that study, the BVR categories were used and the legally blind data were handled discretely from the otherwise visually disabled. TABLE 16. shows this phenomenon clearly again where this situation occurs in categories 50, 51, 52, 53 (all mental disabilities including mental retardation in the National Health Study) and where mental retardation (Category 53) is not included but treated separately, e.g., in the West Virginia reporting. Also, where one study does not present information (such as speech impairment information), another study might. Category 68 also illustrates this. At the present time there is not one complete source, but a great many partial sources for these type of data.

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[1] Ranjit K. Majumder, Ph.D., West Virginia Sample Survey.

C. The Eligible/Feasible Population

Vocational rehabilitation concerns itself primarily with the 14-70 age group and hence the data recorded from the Telephone Survey is limited to that group. People 14-70 in Ohio constitute about 68 percent of the total population. Using 1970 total population figures at the estimated 10,700,000 then the vocational rehabilitation age group consists of about 7,276,000 people.

Other factors to consider in estimating the size of the BVR job to be done would include, in addition to the age variable, the estimates of the portions of the 14-70 age population which could reasonably be expected to be eligible and feasible for BVR services as presently offered. Based on a national rehabilitation rate of about 3.7 million people out of an estimated 180 million, the 2.0 percent figure evolves again. This refers to the historically oriented physical and mental disability aspects and at the present time seems to hold up when applied to BVR type operations when viewed from that perspective.

The Ohio Telephone Survey showed that between 2.1 percent and 2.7 percent of Ohio's population (ages 14-70) are eligible/feasible for vocational rehabilitation. The variance in percentage (from 2.1 percent to 2.7 percent) was due to random sample error calculations and the variance from moderately eligible/feasible to totally eligible/feasible and interested. The 2.1 percent figure was chosen as a base to estimate a minimum number of eligible/feasible Ohioans. Since the Telephone Survey included only those between 14-70 years of age, the 2.1 percent figure is applied to this group of 7,276,000 people. This implies that about 153,000 Ohioans are eligible/feasible for vocational rehabilitation services. Interpolation of this data to the entire state population implies that there are 225,000 eligible/feasible in Ohio. Note that this number includes only mentally and physically disabled.

The socially disabled eligible/feasible population is believed to be about 1.7 percent of the total population, as discussed in later paragraphs. However, one half of the 1.7 percent also have a mental or physical disability, leaving .85 percent or 90,000 socially eligible/feasible to be added to the 225,000 physically/mentally, eligible/feasible. Thus we have a total of 315,000 eligible/feasible persons of all ages or 215,000 eligible/feasible between the ages of 14-70.

There is then, a total of about 215,000 physically, mentally and socially disabled between the ages of 14-70 who are probably eligible and feasible for vocational rehabilitation services; however, some will not be interested. This variable should be a relatively easy one to manipulate and one that will directly influence the number of clients served in a year. At the present time, this interest in accepting services appears to be more likely to increase rather than decrease.

This interest factor was one of the uniquely pertinent findings of the Telephone Survey and resulted from the Counselor Follow-Up where over one half of the cases deemed to be apparently eligible and feasible by reason of a disability did not wish to participate in the vocational rehabilitation program. This expression of lack of interest, negative interest, or lack of motivation, when determined by a random sampling, has considerably more significance than if the information was obtained otherwise.

Another factor to consider in determining the numbers of people to provide for would be the private sector and other public organizations which also work with the disabled to habilitate, restore, or to rehabilitate them, wholly, or in part. Multiple, interdisciplinary efforts are inescapable. In figuring out what share of the tremendous total problem will continue to be handled by state BVR's, (and this varies with the state), that quantity served by other sectors in the state must be established. In Ohio this is a substantial quantity. Indications are that about 11 percent of the physically and mentally disabled who are eligible/feasible, and 6 percent of the eligible/feasible socially disabled appear to be reasonable approximations of the Ohio BVR share. These estimations are in line with regional Task Force findings and studies by Harbridge House, Inc. of Boston, and, under the present conditions, tend to be functional estimations. Therefore, using 11 percent of the physically and mentally disabled eligible/feasible population and 6 percent of the socially disabled, eligible/feasible population, the share factor would indicate that in Ohio in 1970 the group to be served would be made up of about 30,150 people.

Also, in the Telephone Survey/Counselor Follow-Up survey, the social disability factors were limited to the alcoholic. Therefore, in order to assess the social disability segment other sources were used, such as the Harbridge House findings in their studies in Connecticut, Iowa, Maine, Vermont, New Hampshire, and on the national picture, Statewide Planning reports from Pennsylvania, West Virginia, Minnesota and those in Federal RSA Region Five, namely Illinois, Indiana, Michigan, (Ohio), and Wisconsin.

PLANNING REGIONS

AND POPULATION FIGURES

WITH DISABLED POPULATION ESTIMATES

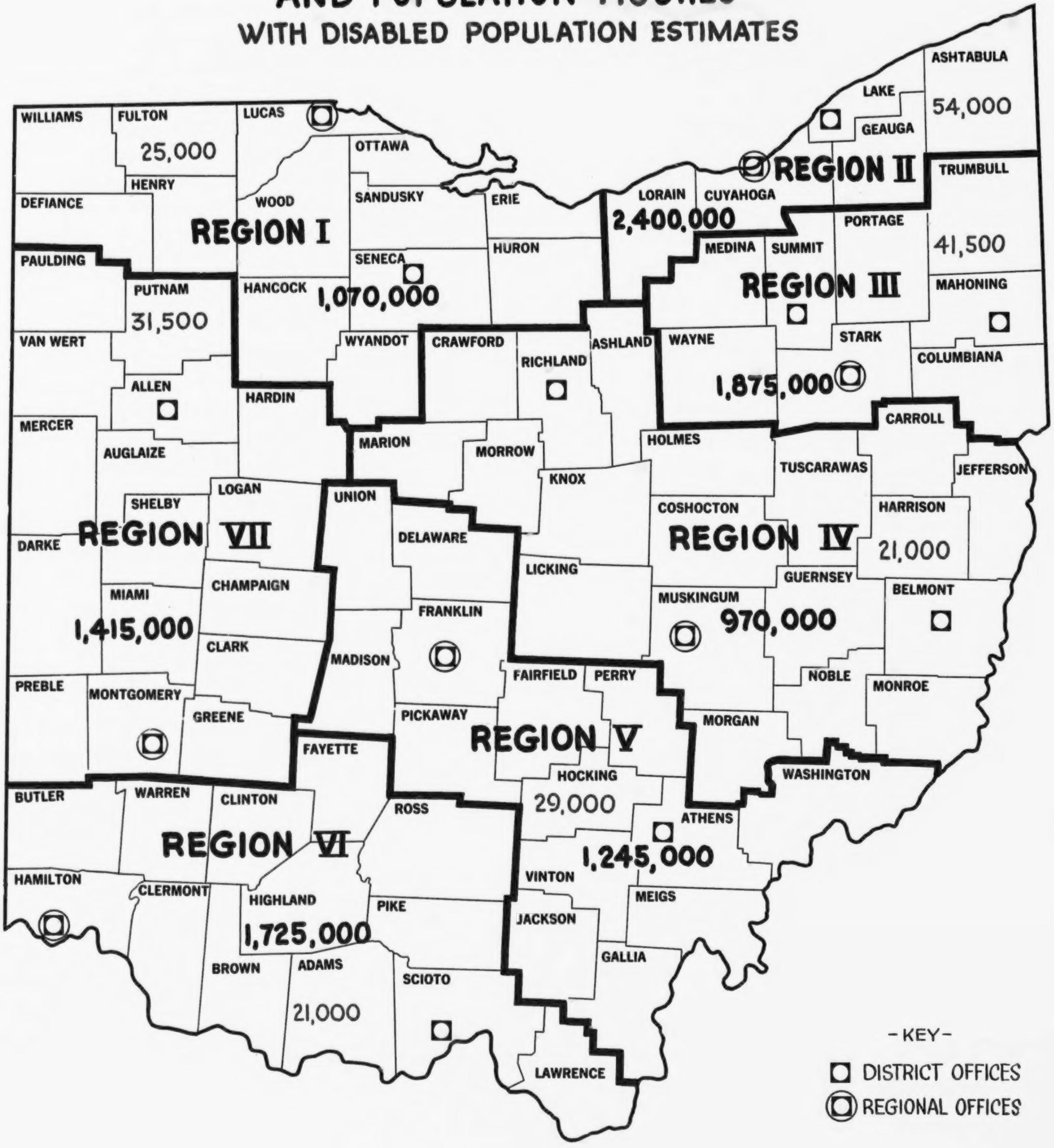

WILLIAMS
FULTON
25,000
LUCAS
OTTAWA
DEFIANCE
HENRY
WOOD
SANDUSKY
ERIE
REGION I
PAULDING
PUTNAM
31,500
HANCOCK
SENECA
1,070,000
HURON
VAN WERT
WYANDOT
CRAWFORD
RICHLAND
ASHLAND
ALLEN
HARDIN
MERCER
AUGLAIZE
MARION
MORROW
KNOX
LOGAN
SHELBY
UNION
DELAWARE
DARKE
REGION VII
CHAMPAIGN
MIAMI
1,415,000
CLARK
MADISON
FRANKLIN
LICKING
PREBLE
MONTGOMERY
GREENE
PICKAWAY
FAYETTE
BUTLER
WARREN
CLINTON
ROSS
REGION VI
HAMILTON
CLERMONT
HIGHLAND
PIKE
1,725,000
BROWN
ADAMS
21,000
SCIOTO
ASHTABULA
54,000
LAKE
GEAUGA
REGION II
LORAIN
CUYAHOGA
2,400,000
TRUMBULL
PORTAGE
41,500
MEDINA
SUMMIT
REGION III
MAHONING
WAYNE
STARK
1,875,000
COLUMBIANA
CARROLL
HOLMES
TUSCARAWAS
JEFFERSON
COSHOCTON
HARRISON
REGION IV
21,000
GUERNSEY
BELMONT
MUSKINGUM
970,000
NOBLE
MONROE
FAIRFIELD
PERRY
MORGAN
REGION V
HOCKING
29,000
WASHINGTON
ATHENS
1,245,000
VINTON
MEIGS
JACKSON
GALLIA
LAWRENCE
-KEY-
DISTRICT OFFICES
REGIONAL OFFICES

FIGURE 17

These additional data were used to estimate the size of the socially disabled population, remove the overlap with social disability and physical and mental disabilities, and, based on existing information, to estimate that portion of the socially disabled population for which state vocational rehabilitation organizations are typically involved. Thus, the share factor and the estimations of eligible/feasible for the socially disabled were empirically as well as vicariously derived to estimate the gap that would have otherwise occured.

Local data was used to estimate the number of institutionalized people who (1) may reasonably be expected to have a physical, mental, or social disability, (2) are eligible and feasible for vocational rehabilitation services, (3) fall into the 14-70 age group, and (4) would actually be interested enough to participate in a rather involved program leading to their successful rehabilitation. This number includes primarily those Ohioans in state mental institutions, state correctional institutions, and in county and community administrated correctional settings. This number approximates from 15,000 to 18,000 and includes those having physical, mental and social disabilities.

None of the above estimates include the fact that about 10.8 percent of BVR's clients at the present time are re-rehabs, and that this rate is fairly typical of the national picture if the legally blind group, which in many states is handled by a separate agency, and which by the nature of the disability will incur a higher re-rehab rate (about 23 percent), is not combined with BVR statistics. Also, these estimates do not include the fact that multihandicapping and overlap complicate the picture and increase the cost per client rehabilitated.

In Ohio, the Telephone Survey results indicate 31 percent of the disabled had two or more disabilities and 11 percent had 3 or more; and the overall result estimates the multihandicapping rate in Ohio at 1.47 disabilities per disabled person in the 14-70 age group. Of BVR rehabilitated clients (1967), only 4.2 percent were multihandicapped. The keeping of accurate records of these secondary, tertiary and quarternary disabilities has not been deemed particularly necessary, nor worthy of the time and work it would take; and therefore, the primary disability, the main reason for accepting the case, is meticulously handled. Other, less crucial, disabilities are routinely handled with the necessary steps taken to alleviate the condition if it is not practical to eliminate it; but these things are taken as a matter of course operationally and special efforts will be needed to ascertain exactly what the multihandicapping patterns are, and what the effect this has on cost factors.

Concerning the findings of the Telephone Survey/Counselor Follow-Up in the categories covered by the survey, which include the mentally disabled, certain salient factors stand out. This study indicated that in the 14-70 age group about 23.3 percent reported at least one disability. This compares with National Health Survey findings that about 12 percent of the total population has a disability. Both of these studies concentrate on physical and mental disabilities and do not equate the social disability as such. Also, they both concern themselves with the non-institutionalized population. The NHS estimates are based on nationally collected data and averaged. In Ohio, a relatively typical state, these extrapolations are naturally closer than would be the case if these data were applied to Alaska, for example.

The Telephone Survey was conducted recently and based on a random sample of Ohioans; it theoretically should more closely depict the Ohio situation. Based on NHS data, about 1,284,000 Ohioans of all ages probably have a physical/mental disability. The Telephone Survey findings indicate possibly 1,695,000 in the 14-70 age group. If the NHS findings are applied to 14-70 this implies 873,000 physically and mentally known disabled who are from 14-70 years of age. The two studies indicate that from 12 to 16 percent of the total population of the state could be expected to have at least one disability (physical or mental, or both). West Virginia's Statewide Planning random sample indicated about 14 percent. Pennsylvania's study by Greenleigh, Inc., New York, estimated 1.4 million disabled in 1968, or about 12 percent of the total population.

However, as is obvious from the preceding derivations, the picture is not simple, clear-cut, not static, but rather has many factors to be considered and many of the variables are easily influenced by attitude, legislation and economics. Factors that are easily overlooked include the previously used disability categories, that tend to overlap as in multihandicapping, of physical, mental and social; the fact that about 10.8 percent of the rehabilitations are for the second time or more; the fact that in deciding upon a primary justification for eligibility, due to the historical influence, the physical disability is more likely to be selected first, the mental second, and a social disability will be used last in order. Hence, these factors are not equated evenly. It is important to understand that all ages are not equally eligible/feasible for VR; that there are others besides state VR organizations who also share responsibility for rehabilitating all or part of the various groups; and that the people involved have their own personal interest in, or motivation toward, accepting services and this is a highly individualistic variable.

Another factor is that within disability categories the estimates of the numbers involved varies from low to high depending upon a great many variables and how they are grouped, etc. However, the Telephone Survey/Counselor Follow-Up study was made to relate its findings to the State of Ohio, the Ohio Bureau of Vocational Rehabilitation, and the Bureau of Services for the Blind, with the purpose of establishing reasonable quantities on which to predict anticipated work loads and to relate these plans to service of those who appear to be most in need of rehabilitation services.

D. Multihandicapping Conditions

Concerning the multihandicapping factors, certain information is currently available, and increasingly more is becoming available; however, this is an area that has had a minimum of scrutiny. Reading through the materials on disability such items as those just reviewed are found; they seem to indicate that the combination of disabilities may be more handicapping than a sum of the separate disabilities would indicate. Shedding some light on these problems are items that were encountered in this study and its counterparts in other states which include the following:

Connecticut: "about 70 percent of the blind children have additional complications."

Indiana: "it is estimated that there are, 3,000 children in it multihandicapped population."

Some indications of multihandicapping, overlap, and difficulty in assessing the disabled population are clearly shown in the Telephone Survey. The following data refers to that study:

Ohio Telephone Survey/Counselor Follow-Up: "Multiple handicapped rate 1.47 per disabled person in the 14-70 age group."

Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin (six states at 2,000 per state random sample) results showed:

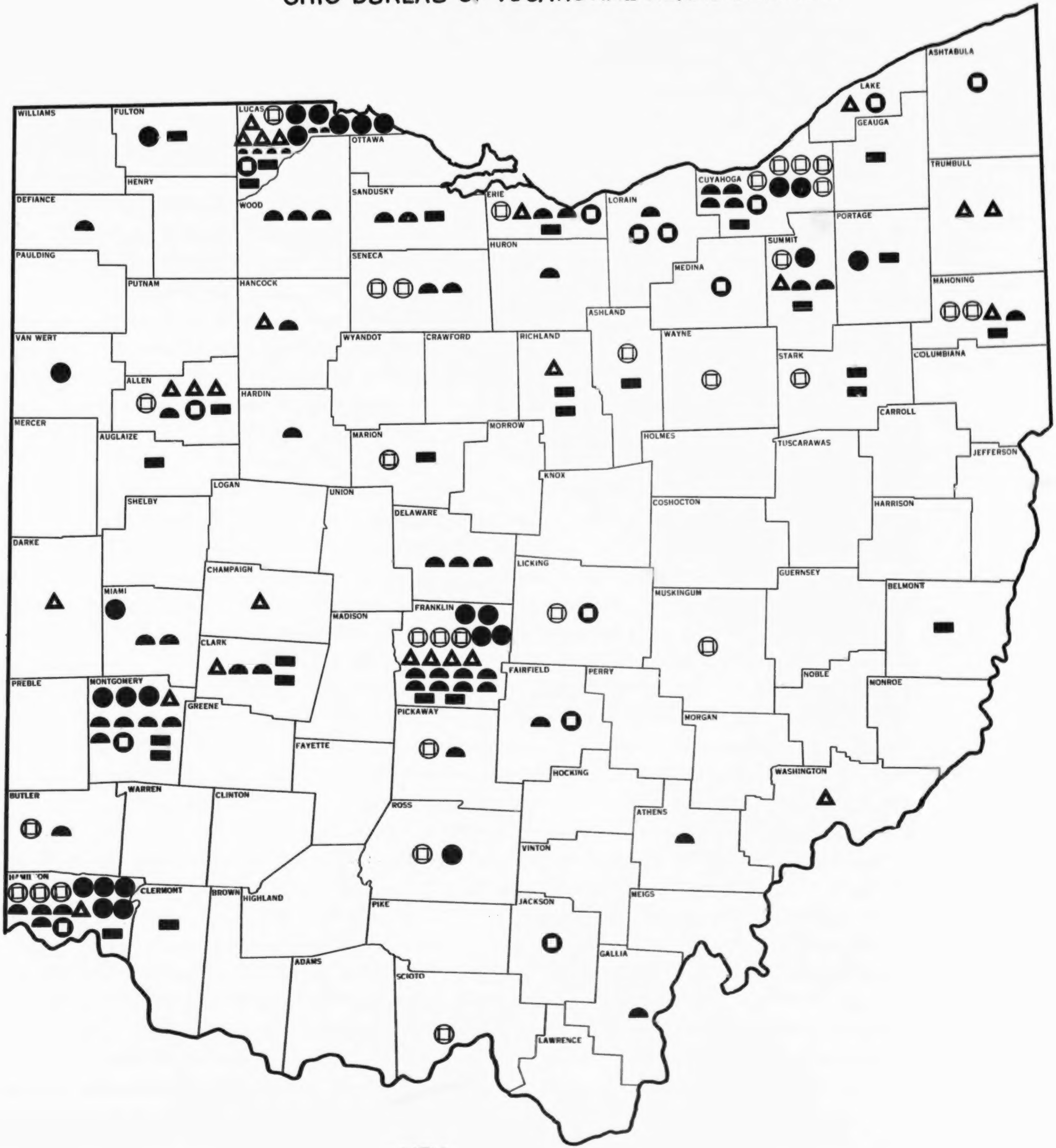
23 percent of the households reporting had a person with one disability living there;

31 percent of the disabled had two or more disabilities;

11 percent of the disabled had three or more disabilities.

PARTIAL LISTING OF OHIO'S REHABILITATION FACILITIES

SELECTED FROM THOSE WORKSHOPS
AND FACILITIES DIRECTY INVOLVED WITH
OHIO BUREAU OF VOCATIONAL REHABILITATION


ASHTABULA
LAKE
GEAUGA
WILLIAMS
FULTON
LUCAS
OTTAWA
HENRY
DEFIANCE
WOOD
SANDUSKY
ERIE
LORAIN
CUYAHOGA
TRUMBULL
PORTAGE
PAULDING
HURON
MEDINA
SUMMIT
PUTNAM
HANCOCK
SENECA
MAHONING
ASHLAND
VAN WERT
WYANDOT
CRAWFORD
RICHLAND
WAYNE
STARK
COLUMBIANA
ALLEN
HARDIN
MERCER
AUGLAIZE
MARION
MORROW
HOLMES
TUSCARAWAS
CARROLL
JEFFERSON
KNOX
LOGAN
UNION
SHELBY
DELAWARE
COSHOCTON
HARRISON
DARKE
CHAMPAIGN
LICKING
GUERNSEY
BELMONT
MIAMI
MADISON
FRANKLIN
MUSKINGUM
CLARK
PREBLE
MONTGOMERY
GREENE
FAIRFIELD
PERRY
NOBLE
MONROE
PICKAWAY
MORGAN
FAYETTE
HOCKING
WASHINGTON
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
CLERMONT
BROWN
HIGHLAND
PIKE
JACKSON
MEIGS
GALLIA
ADAMS
SCIOTO
LAWRENCE

-KEY-

⊡ MULTI-SERVICE, MULTI-DISABILITY
● MULTI-SERVICE, SINGLE DISABILITY
△ MEDICAL OR MEDICALLY RELATED SERVICE, MULTI-DISABILITY
◓ MEDICAL OR MEDICALLY RELATED SERVICE, SINGLE DISABILITY
○ SHELTERED SHOP, MULTI-DISABILITY
▬ SHELTERED SHOP, SINGLE DISABILITY

FIGURE 18

Of the 1967 BVR (Ohio) rehabilitated clients, about 4.2 percent were multihandicapped. With more accurate reporting, less stringent eligibility/ feasibility requirements and improved diagnostic techniques, it seems reasonable to anticipate more multihandicapped clients. Possibly the 4.2 percent figure is a minimum and is only this size because of lack of comprehension of the problem.

E. Special Categories of Disabled/Disadvantaged

There are several aspects of the statewide estimates of disabled Ohioans who must also be considered as potential clients for a rehabilitation system and who for reason of their location, such as rural, inner-city, or institutional environment are not adequately covered in most surveys to date, thus, the following data sheets are an effort to present what information is presently available, and to base estimates on the best information obtainable at this time. These estimates are intended to serve as a take-off point for more detailed study when such undertakings appear feasible. They do show certain characteristics and trends on which some immediate action could be taken. As in the case of the social disabilities, a dearth of information precludes anything but rough estimates and generalizations now. Hopefully, in the years ahead, more detailed data will evolve.

1. Socially Disabled

For the purpose of the Ohio Comprehensive Statewide Planning for Vocational Rehabilitation, this disability category has been construed as including primarily the social offender, the drug addict, the alcoholic, and the culturally/educationally deprived. Being a relatively new way of perceiving a disability, as compared with the physical disabilities, there is a dearth of pertinent information related to this group as it applies to the rehabilitation/habilitation process. Definition of terms and relationships to handicapping is not clear and precise. As a result, much of the existing data is not applicable and a different approach is needed to research this category. Task Force involvement was an effort to get grass-roots information on the 88 Ohio counties in terms of the social disability group and its needs. These reports are included in the seven Regional reports. The information presented here is in addition to that data and in order to avoid duplication, is brief and perhaps random; however, if it were not included here, it might be overlooked by those who will use this study and its reports for future investigations. Some general information relating to the socially disabled and which is presently coming to light as a result of Statewide Planning for Vocational Rehabilitation would include the following:

Illinois Comprehensive Statewide Planning Project reports about 15 percent of the families of that state have an income of less than $3,000 per year. (By definition economically deprived). High school dropouts average 25 percent of the total population. Estimates of the socially disabled population (excluding the poverty stricken) place the figure at 2.09 percent of the total population of the state. In urban depressed areas, the socially disabled population is estimated at 27 percent of the total population of that area. There appears to be a 300 percent relationship between disability and poverty. (The figure of three times the disability rates for the lowest income groups and older citizens seems to be a consistent one).

Michigan statewide planners for vocational rehabilitation have learned that households of the poor average 21 percent larger than the statistically popular "family of four". In households supported by incomes of less than $3,000 per year, 20.6 percent of the persons exhibited conditions limiting or excluding major activities. In the 45-60 age group, the disabled segment averaged about 1.4 percent as contrasted to the 65 years and older group where about 40 percent were disabled.

In West Virginia's statewide planning survey, it was found that 20.2 percent of its families were socially handicapped.

Estimates of 5.8 percent of the total population may be reduced to the following inputs; namely, alcoholic, public offender, and drug addict totaling 2.1 percent plus the economically disabled at 3.7 percent. Under reporting, which is often given as a reason for the conservatism in National Health Study figures, is probably also a factor in gathering data related to social disabilities. It seems reasonable that the hesitancy to report or discuss these social disabilities will lessen in the future rather than increase; hence, the recent studies, and future surveys, may more realistically depict the incidence and prevalence of disabilities than is true at the present time where, for example, estimates on the number of mentally ill range from one percent to 33 percent.

In the case, on earlier data, of the mentally retarded, this disability was included with the mentally ill, NHS for example. Later, a 3 percent figure was used, however, more recent refining tends to indicate 1.6 percent to be more closely indicative of the prevalence of mental retardation and that this figure varies with the age of the group studied.

It is too early in the game to draw reliable conclusions in the social disability fields, especially when this is related to the rehabilitation picture, but the pieces are coming in and as they go together, trends are showing up. Thus the estimate of the public offender as a disabled person appears to be emerging at .06 percent of the total population.

a. The Alcoholic

Alcoholism in the rehabilitation discipline is typical of the confusion in the social disabilities subcomponents in that it is classified in some reports as a physical disability because of its physiological characteristics, as a mental disability because of its behavioral aspects, as a psychosocial disorder, e.g., the West Virginia survey, and is a social disability in other studies. Therefore as in the case of all the other social disabilities it is not clearly differentiated from the physical and mental disabilities. It, also, is tied in with multihandicapping situations, hence, alcoholism as a disability is not clear cut nor is the data concerning it really what is needed in terms of the rehabilitation process.

Pennsylvania's statewide planning studied the data on alcoholics by putting it into a separate category. Their findings that about 2.85 percent of their total population are alcoholics would infer that in the Ohio 14-70 population about 207,000 would be alcoholics. Wisconsin data shows 130,000 alcoholics out of a total state population of four million, or about 3.25 percent. For Ohio, 14-70 this would imply possibly 236,000 alcoholics. Interestingly, Wisconsin data breaks the data down to show 20-29 at 9.3 percent. 30-39 at 22.9 percent, 40-49 at 27.1 percent, 50-59 at 5.7 percent, and 60 and over years of age at 14.8 percent (percents are percentages of the total number of alcoholics).

In Ohio, using the 1970 population figure of 10,700,000, about 289,000 people are believed to constitute the alcoholic population, or about 2.7 percent. Subtracting those estimated as eligible for service because they also have physical and/or mental disabilities, then about 12 percent or 34,700 people would be removed thus reducing the disability configuration of social with at least predominately alcoholism to 254,000. If BVR's 6 percent of a social disability is the size of the total universe which is needed to have the input to the universe equal the output and thus evolve a size estimate for the operation which will be maintained, or referred to as the BVR share or responsibility for the process, this then appears to indicate that a caseload of 15,000 alcoholics a year is reasonable, and that if in this group, about

OHIO YOUTH COMMISSION

FACILITIES FOR YOUTHFUL OFFENDERS

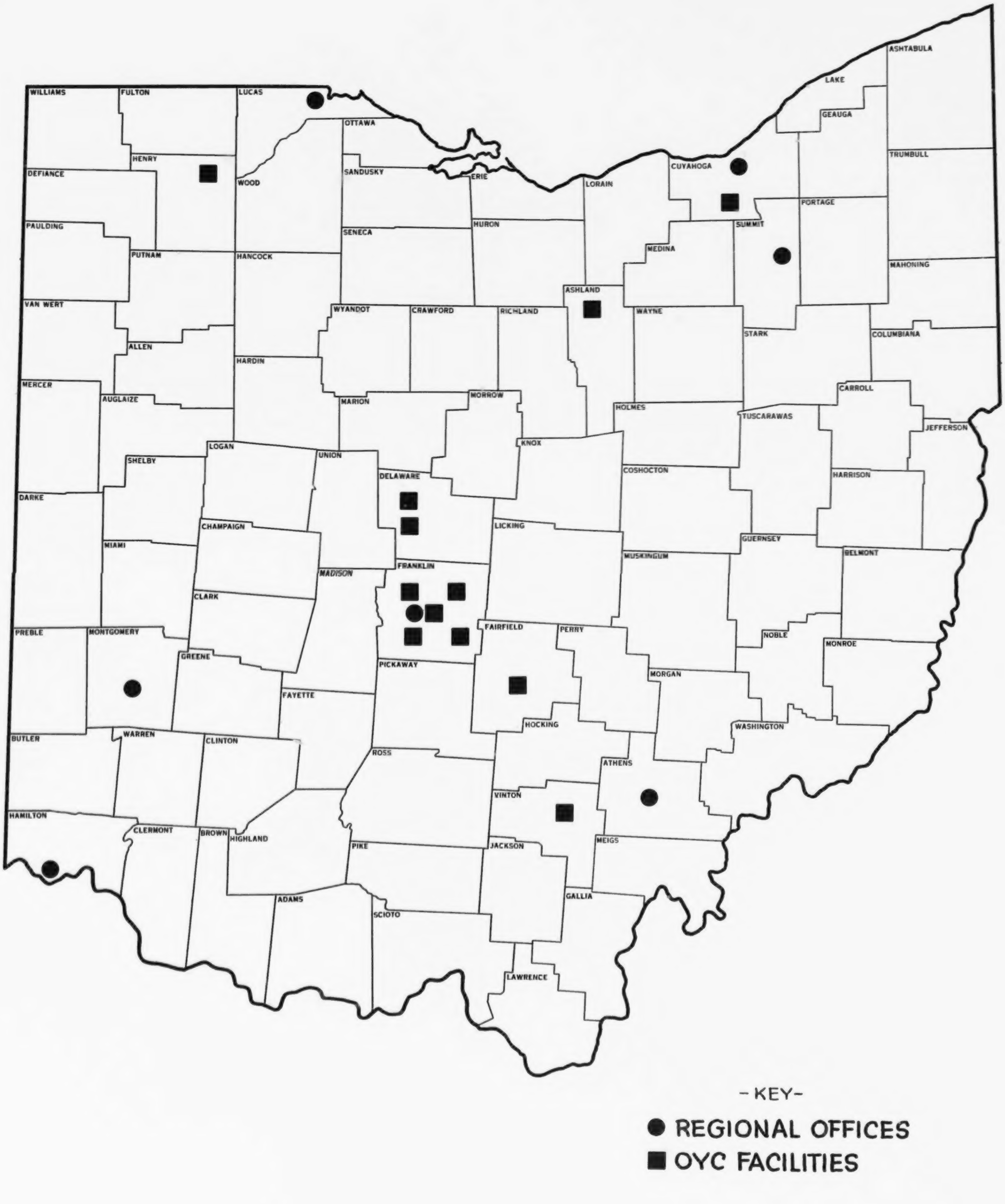

WILLIAMS
FULTON
LUCAS
OTTAWA
HENRY
DEFIANCE
WOOD
SANDUSKY
ERIE
LORAIN
CUYAHOGA
LAKE
GEAUGA
ASHTABULA
TRUMBULL
PORTAGE
SUMMIT
MEDINA
HURON
SENECA
HANCOCK
PUTNAM
PAULDING
VAN WERT
ALLEN
MAHONING
ASHLAND
WAYNE
STARK
COLUMBIANA
WYANDOT
CRAWFORD
RICHLAND
HARDIN
MERCER
AUGLAIZE
MARION
MORROW
HOLMES
TUSCARAWAS
CARROLL
JEFFERSON
LOGAN
UNION
KNOX
SHELBY
COSHOCTON
HARRISON
DELAWARE
DARKE
CHAMPAIGN
LICKING
MIAMI
GUERNSEY
BELMONT
MUSKINGUM
FRANKLIN
MADISON
CLARK
PREBLE
MONTGOMERY
FAIRFIELD
PERRY
NOBLE
MONROE
GREENE
PICKAWAY
FAYETTE
MORGAN
HOCKING
WASHINGTON
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
CLERMONT
BROWN
HIGHLAND
PIKE
JACKSON
MEIGS
GALLIA
ADAMS
SCIOTO
LAWRENCE
-KEY-
● REGIONAL OFFICES
■ OYC FACILITIES

FIGURE 19

one half evince interest in participating in VR services, then an annual Ohio BVR caseload of from 5,000 to 10,000 alcoholics could be estimated.

b. The Drug Addict

Concerning drug addicts, possibly the major investigations have been conducted in Ohio by the Task Forces on Social Disabilities, Region V having a series of seminars on this and related topics. Pennsylvania's statewide planners found that about .0125 percent of the total state population would come under this classification. If the situation is similar in Ohio, this would infer about 1,500 such individuals. There is much to be done in the area of rehabilitating the addict through BVR services. While this particular two-year study was noticeably comprehensive and investigated a great many aspects of the rehabilitation scene, there are many areas that were, because of limitations of time and funding, primarily identified only by obvious characteristics, and limited to pointing out to future investigators areas which seem to have excellent research potential.

2. Institutional Populations

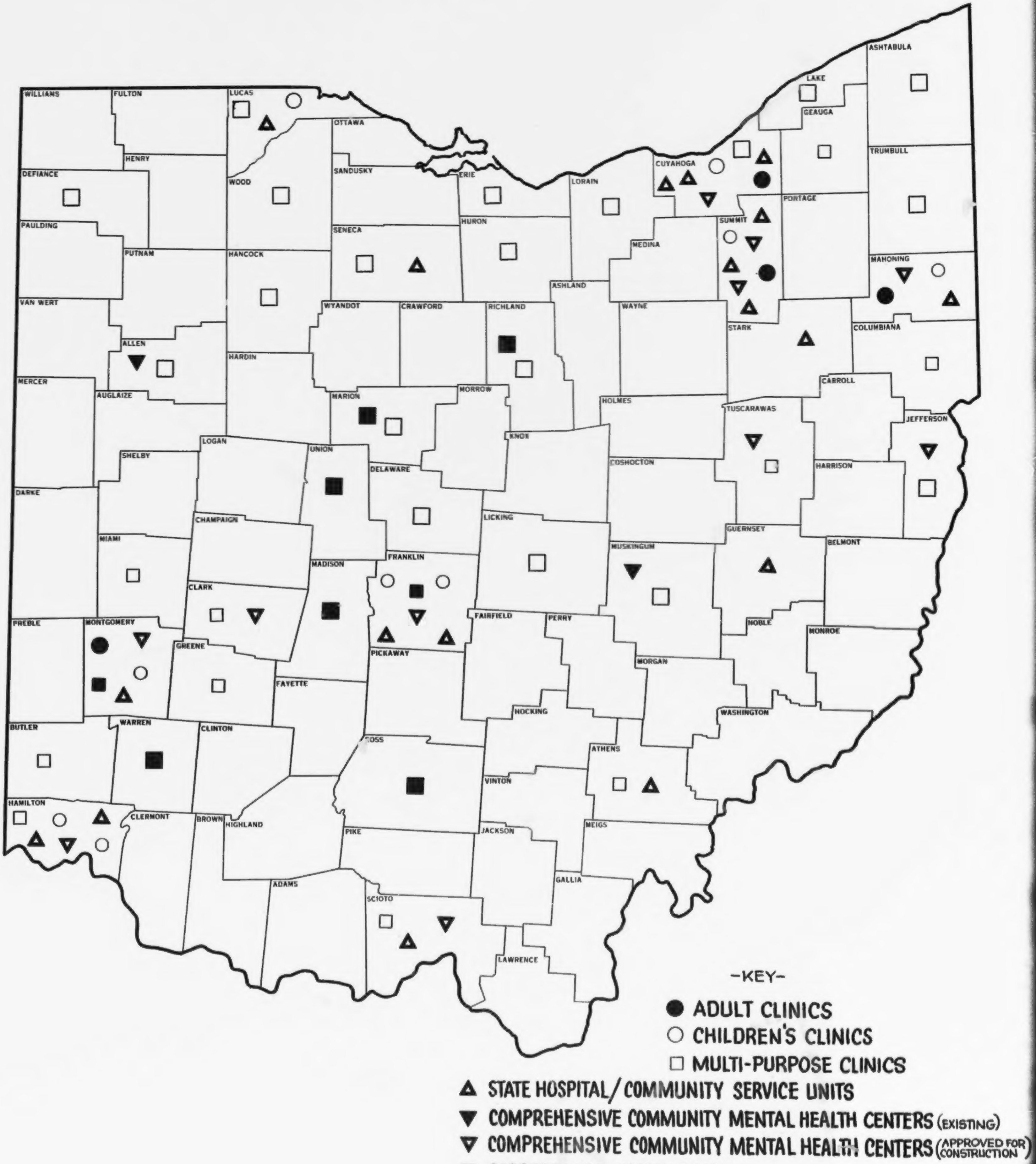
As in the surveys and disability incidence/prevalence studies, the institutionalized populations are not included in this analysis of the rural populations of Ohio, however, the following portion of this report attempts to shed light on the institutional sector as it relates to the overall statewide plan.

Studies made by the Vocational Rehabilitation Administration (RSA) indicate that about 6 percent of the eligible/feasible population of a state are institutionalized. The total eligible/feasible population of the State of Ohio is estimated at 2.85 percent of the 10,700,000 or 305,000 people, 6 percent of which would indicate that about 18,300 people, would be so involved and include physical, mental, and social disabilities. Some of these people would be on parole or institutionalized nightly, but regularly outside the institution on some project. The patterns become quite complex when arranging for services in some of these situations.

a. Correctional Programs

The Ohio state correctional institutional segment includes 4,000 state parolees, and 4,500 from the correctional population, plus the state mental hospital portion at 4,600, plus the county/community corrections estimate at 3,200 totals up to

FACILITIES FOR THE EMOTIONALLY ILL AND ADULT CORRECTION


WILLIAMS
FULTON
LUCAS
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LAKE
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CUYAHOGA
TRUMBULL
PORTAGE
PAULDING
PUTNAM
HANCOCK
SENECA
HURON
MEDINA
SUMMIT
MAHONING
VAN WERT
WYANDOT
CRAWFORD
RICHLAND
ASHLAND
WAYNE
STARK
COLUMBIANA
ALLEN
HARDIN
MERCER
AUGLAIZE
MARION
MORROW
HOLMES
TUSCARAWAS
CARROLL
JEFFERSON
LOGAN
UNION
KNOX
SHELBY
DELAWARE
COSHOCTON
HARRISON
DARKE
CHAMPAIGN
LICKING
GUERNSEY
BELMONT
MIAMI
MADISON
FRANKLIN
MUSKINGUM
CLARK
PREBLE
MONTGOMERY
GREENE
FAIRFIELD
PERRY
NOBLE
MONROE
PICKAWAY
MORGAN
FAYETTE
HOCKING
WASHINGTON
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
CLERMONT
BROWN
HIGHLAND
PIKE
JACKSON
MEIGS
GALLIA
ADAMS
SCIOTO
LAWRENCE
-KEY-
● ADULT CLINICS
○ CHILDREN'S CLINICS
□ MULTI-PURPOSE CLINICS
△ STATE HOSPITAL/COMMUNITY SERVICE UNITS
▼ COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS (EXISTING)
▽ COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS (APPROVED FOR CONSTRUCTION)
■ CORRECTIONAL INSTITUTIONS

SOURCE OF INFORMATION - OHIO DEPARTMENT OF MENTAL HYGIENE AND CORRECTION

FIGURE 20

about 16,300 potential referrals from these combined sources. Acutally, this population varies widely, is often under jurisdiction which precludes easy contact, communication, access, or provision of services other than by a strict adherence to the rules and conditions associated with the case, so, in many ways, the actual working with 16,300 referrals from these sources and of these types might well be considerably more time-consuming than an equivalent number of less structured referrals. Interagency and interdisciplinary relations become quite complicated and appear to be fertile ground for research as to the best methods to use to accomplish the rehabilitation of persons supervised by other such agencies.

In 1967 there were about 4,900 people on parole in Ohio. Those people who have worked with these parolees estimate that a high percentage appear to need VR services, possibly as high as 95 percent. The exact data is not yet available, but there is reason to believe it will run higher than 21 percent physical/mental disability or an equivalent number of socially disabled. If, e.g., 90 percent of this 4,900 parolees can be reviewed as potential referrals, this would indicate about 4,000 individuals would be so involved. This group is reported to be seriously lacking in educational achievement, vocational skills, and these are complicated by physical, mental, and social problems.

b. State Mental Hospitals

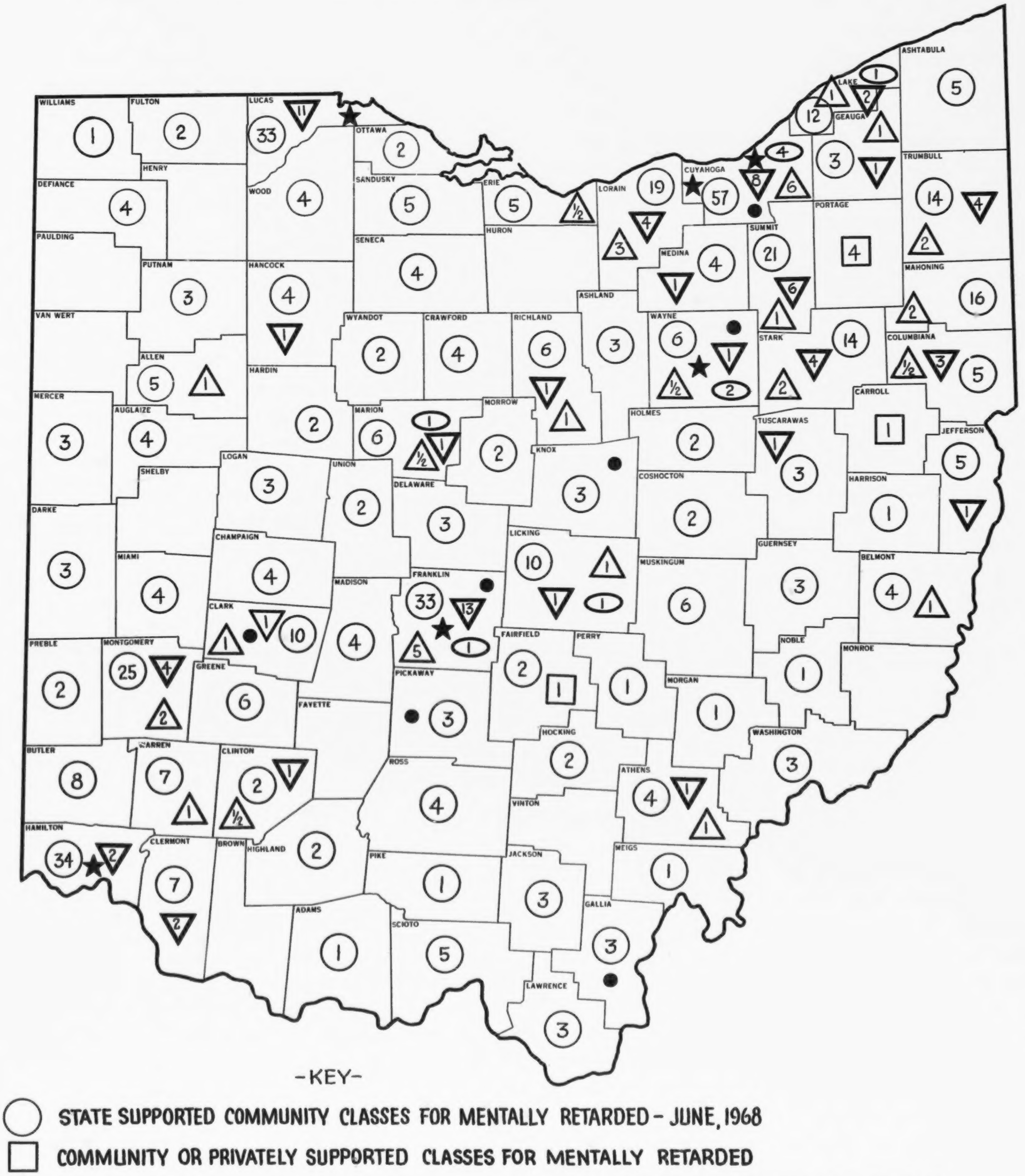
The state mental hospital segment, estimated at 4,600 potential referrals, is based on the Harbridge House VR studies indicating that about 15 percent of the total state mental hospital patient population appears to be eligible and feasible for VR services. This includes not only the mental disabilities, but also the physical and social disability involvement. The Ohio state mental hospital population was determined to be approximately 30,900 as May 1, 1968. If by 1970, the state mental hospital population increases proportionately to the general population increase, about 5 percent to 6 percent increase would also be reflected, the 4,600 becoming about 4,900 potential referrals who could be expected to qualify for services. The influence of patient interest in receiving services is not included in this estimate.

c. General Summary on Institutional Populations

Some of the information gathered from a variety of sources during the past two years indicate the following situations and

OHIO DEPARTMENT OF MENTAL HYGIENE AND CORRECTION

SERVICES FOR THE MENTALLY RETARDED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LUCAS 33 11
OTTAWA 2
DEFIANCE 4
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LORAIN 19 3 4
CUYAHOGA 57 4 8 6
LAKE 1 2 1
GEAUGA 12 3 1 1
ASHTABULA 5
TRUMBULL 14 4 2
PAULDING
PUTNAM 3
HANCOCK 4 1
SENECA 4
HURON
MEDINA 4 1
SUMMIT 21 6 1
PORTAGE 4
MAHONING 16 2
VAN WERT
ALLEN 5 1
WYANDOT 2
CRAWFORD 4
RICHLAND 6 1 1
ASHLAND 3
WAYNE 6 1 1/2 2
STARK 14 4 2
COLUMBIANA 1/2 3 5
MERCER 3
AUGLAIZE 4
HARDIN 2
MARION 6 1 1/2 1
MORROW 2
HOLMES 2
TUSCARAWAS 1 3
CARROLL 1
JEFFERSON 5 1
SHELBY
LOGAN 3
UNION 2
DELAWARE 3
KNOX 3
COSHOCTON 2
HARRISON 1
DARKE 3
MIAMI 4
CHAMPAIGN 4
LICKING 10 1 1 1
MUSKINGUM 6
GUERNSEY 3
BELMONT 4 1
CLARK 1 1 10
MADISON 4
FRANKLIN 33 13 5 1
PREBLE 2
MONTGOMERY 25 4 2
GREENE 6
FAIRFIELD 2 1
PERRY 1
NOBLE 1
MONROE
MORGAN 1
PICKAWAY 3
FAYETTE
HOCKING 2
WASHINGTON 3
BUTLER 8
WARREN 7 1
CLINTON 2 1 1/2
ROSS 4
ATHENS 4 1 1
VINTON
HAMILTON 34 2
CLERMONT 7 2
BROWN
HIGHLAND 2
PIKE 1
JACKSON 3
MEIGS 1
GALLIA 3
ADAMS 1
SCIOTO 5
LAWRENCE 3

-KEY-

○ STATE SUPPORTED COMMUNITY CLASSES FOR MENTALLY RETARDED - JUNE, 1968

□ COMMUNITY OR PRIVATELY SUPPORTED CLASSES FOR MENTALLY RETARDED

△ HOME TRAINERS

● MENTALLY RETARDED INSTITUTES AND SCHOOLS

⬭ SPECIAL THERAPISTS FOR RETARDED

▽ DEVELOPMENT CLASSES FOR RETARDED

★ CLINIC AND HOSPITAL COMMUNITY UNITS SPECIFICALLY FOR CARE OF MENTALLY RETARDED

FIGURE 21

trends to be reasonably typical of what exists at this time. For example, a minimum estimate of 15,000 to 18,000 individuals in the 14-70 age group who appear to be eligible and feasible for VR services and whose disabilities include the physical, mental, and social categories, and who could be expected to be motivated and interested toward accepting services, are presently institutionalized in state mental hospitals, state correctional institutions, or in municipal and county court/workshop situations.

At the present time, the population of Ohio state correctional institutions over 18 years of age is about 9,100 people. The VR potential of these people is relatively unknown, but even if one half of these were to be referred for reasons relating to physical, mental and social disabilities approximately 4,500 people would be referred from this source.

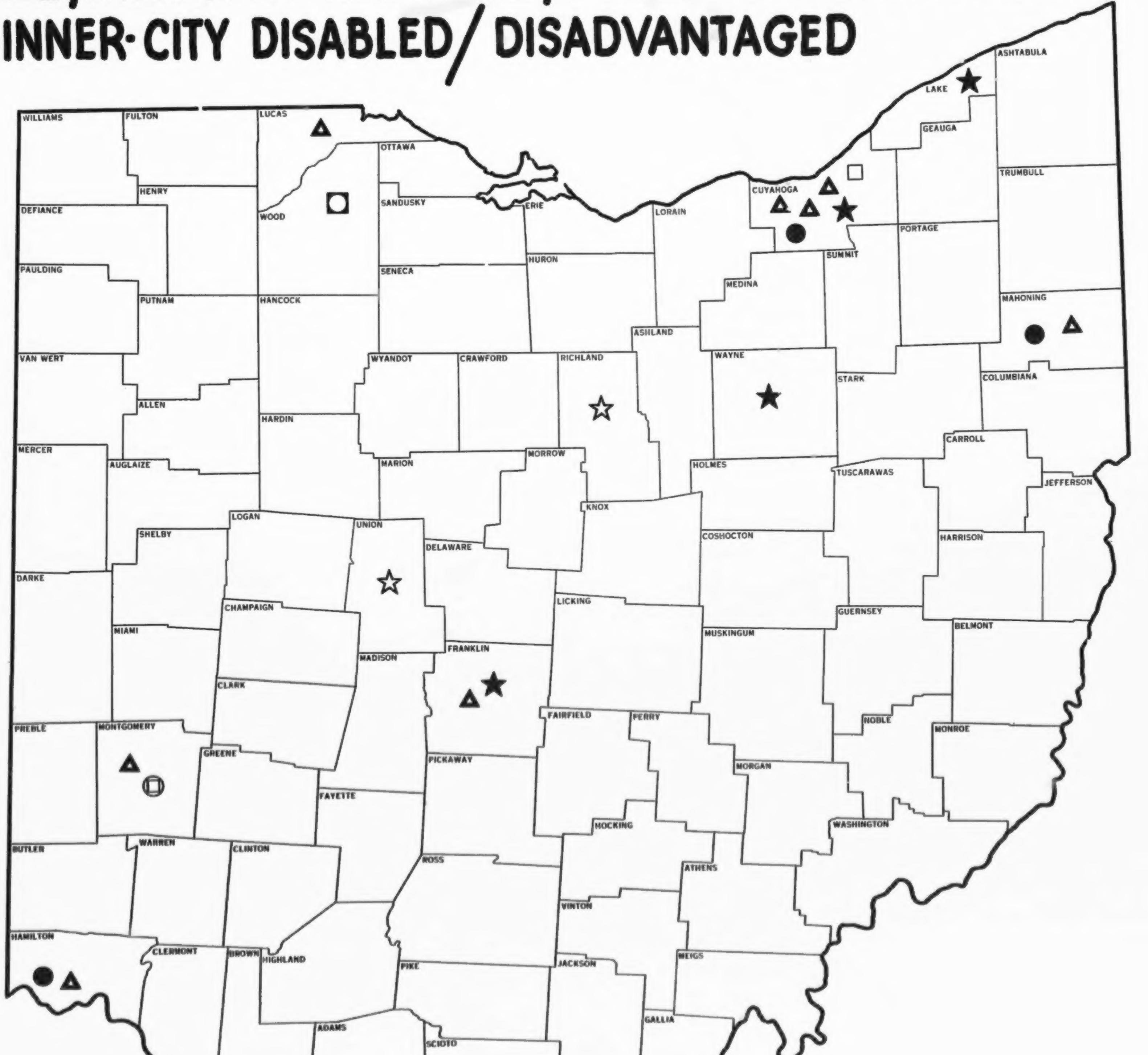
An estimated 6,500 people are in Ohio non-state institutional operations. These would include the relatively little known statistically from a VR standpoint, local, community, county workshops/court cases. Again, if one half were referred, about 3,200 referrals would be added to the list of those for whom VR services might be applicable.

In the Fiscal Year 1967, about 14.2 percent of the BVR referrals came from state hospitals and sanatoriums. BVR referrals for that period stood at 19,435. Thus, BVR received about 2,760 referrals from that source. In the same period, about 6.4 percent of BVR 19,435 new annual referrals came from state correctional institutions, or about 1,244.

3. The Inner City Disabled/Disadvantaged

The Inner City -- while not a disability per se, it is not unlikely that the ecological residue in many cases results in a higher rate of disablement than average, and with certain characteristics predominating. Thus, the Inner City as a biome contains its peculiar hazards and tends to produce disability. Some of the recent studies of the Inner City, and there are indications that several large, complex in-depth research studies are planned for the next half a decade, are finding out that about 8.6 percent of the inhabitants are unable to engage in a major life activity due to a physical or mental disability, that the disability prevalence rate tends to run about twice the national average of 12 percent, and that estimates from 17 percent to 34 percent on the prevalence of disability related to the Inner City universe seem to be realistic. Also, where extreme poverty is widespread, the ratio

OHIO BUREAU OF VOCATIONAL REHABILITATION SPECIAL REHABILITATION UNITS FOR THE EMOTIONALLY ILL, MENTALLY RETARDED, PUBLIC OFFENDER AND INNER-CITY DISABLED/ DISADVANTAGED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TRUMBULL
DEFIANCE
PORTAGE
SUMMIT
PAULDING
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VAN WERT
WYANDOT
CRAWFORD
RICHLAND
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HARDIN
CARROLL
MERCER
AUGLAIZE
MARION
MORROW
HOLMES
TUSCARAWAS
JEFFERSON
KNOX
LOGAN
UNION
SHELBY
DELAWARE
COSHOCTON
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FRANKLIN
CLARK
FAIRFIELD
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MONROE
PREBLE
MONTGOMERY
GREENE
PICKAWAY
MORGAN
FAYETTE
HOCKING
WASHINGTON
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
CLERMONT
BROWN
HIGHLAND
PIKE
JACKSON
MEIGS
GALLIA
ADAMS
SCIOTO
LAWRENCE

-KEY-

△ HOSPITALS FOR MENTALLY ILL
★ INSTITUTIONS FOR MENTALLY RETARDED
☆ CORRECTIONAL INSTITUTIONS
▢ AREA VOCATIONAL SCHOOLS
⊡ SPECIAL EDUCATION PROGRAMS
● OCCUPATIONAL SCHOOLS
□ INNER-CITY PROJECT

FIGURE 22

approximates three times the rate for the general population.

It is not unusual to find such rates as TB at four times the state average; cirrhosis, two times; and, influenza, two times; or that many Inner City residents have never held a job, or that many are marginally employed. A large percentage of the working age population is considered to be composed of unskilled workers. The high school drop out rate is about 70 percent. Of the Inner City students, approximately 30 percent are below the expected norm for the age group.

In the Inner City, vocational rehabilitation counselor caseloads typically include about 25 percent mentally retarded clients. When the number of educationally retarded clients is added to the MR group, the percent of these on the caseload may total up to 40 percent of the counselor's clients, with many persons having both disabilities. Inner City VR clients tend to be primarily under 25 years for the majority and the next largest group age-wise over 35 years of age.

4. The Rural Disabled

In Ohio 28 counties are classed as being "Appalachian". Here 2/3 of the rural youth do not finish high school, the unemployment rate is $\frac{1}{2}$ again higher than the national average, and the disability rates also run above the national average especially in the more poor rural areas. In the Appalachian environment, resources leave, or are taken out, in greater quantities than are returned; e.g., humans leave, (the good workers usually); minerals, oil, gas, and coal are removed; water, timber, crops, and other natural resources are taken out of the area leaving the farm-rural areas impoverished and with reduced productivity. Money inputs tend to go for roads, hospitals, libraries and other bricks and mortar expenditures; however, direct help to people, help to help them help themselves in less well developed areas appears to be lacking or in insufficient quantities.

Rural populations look to their local communities, county-seats, town and villages for leadership and as a focal point for action or services. From these centers, programs designed to work with rural individuals can be based. Travel is a problem in rural areas, and getting services to people, and people to services is complicated by distance, weather effects, and lack of communications, isolation, and local attitudes. The problems of determining needs, developing programs to meet these needs, getting the necessary facilities, manpower, etc., needed to meet the objectives, are problems of a different nature than those in the Inner City; however, they appear no less challenging. The solution is not to bring everyone into the city. Even though the actual numbers of people working Ohio's farms will be greatly decreased, the non-farm rural population will become involved with new enterprises brought about in part by projects such as dams, recreation areas, reclamation activities, and decentralized industrial complexes. The rural disabled, including the uncomplicated socially disabled individual, will provide a real challenge for rehabilitation management.

Data relating to the rural disabled currently includes the following: Calculations (Michigan Statewide Planning) indicating an estimated 12.5 percent of the farm population has a disability. In Ohio, the farm population is estimated at 400,000 (1968), the rural non-farm population estimate is 2,000,000, or therefore, 2,400,000 ruralites. Not all these are living in Appalachia, obviously, but those in 28 of the 88 Ohio counties are. At 12.5 percent, therefore, the disabled farm population appears to be 50,000, and the rural non-farm disabled population at 250,000, making a potential of disabled ruralites about 300,000. About 40,000 may be added to this to include the socially disabled without physical or mental complicating disabilities figured at 1.7 percent of the total 2,400,000 rural population, the 300,000 being primarily physical/mental disabled.

5. Ohio's Migrant Worker

Ohio's 117,000 farms typically require about 17,000 hired seasonal farm workers per year. At the peak September harvest season this figure temporarily reaches about 33,000 migratory workers. Without this additional help certain Ohio farmers would not be able to produce the quantities that they presently do. Crops that require additional seasonal farm labor include: tomatoes, apples, potatoes, pickle cucumbers, cherries, and sugar beets. In the future, more of this type work will be handled by machinery, but at the present time human field hands are needed to do the job.

Migrant workers come primarily from the Florida-Eastern Seaboard route, or from the Central States route which begins in Texas. Ohio is but one of a long series of crop handling involvements by these people. There is increasingly stiff competition for their services as the total number of migratory workers available relative to the amount and distribution of the work is decreasing. Ninety percent of the Ohio migrant worker population come from Texas, are of Mexican abstraction, and move in and out of Ohio as families. Ten percent of the migrant workers are Negroes from the Southeast U.S. Last year contract Puerto Ricans worked in the Lake Erie area. Over 80 percent of the migrants work in the 19 counties of Northwestern Ohio.

Migrant workers, in addition to problems related to the fact that many only communicate in Spanish, and that the educational level of achievement is lower than that found in the communities in which they work, also have, as do all people everywhere, illnesses and accidents to contend with. Legal, financial, health and clothing are other areas in which need is in evidence. The group is typically also in need of service to its pregnant mothers, its infants, young children, and youth. The Department of Education enrolled 1,621 pupils in 1966. Other agencies public and private assist the migrants in finding the work, and locating the services they need. The role of the State Rehabilitation Agency in this picture will become clearer when a more complete profile of the migrant worker, his life, and resources available to him and his family is developed.

F. Architectural Barriers

The Governor's Council on Vocational Rehabilitation drew upon many sources for information concerning architectural barriers. A primary source of information was the Report of the National Commission on Architectural Barriers to Rehabilitation of the Handicapped entitled, "Design for All Americans". This report contains an exhaustive summary of the problems, progress, and recommendations concerning Architectural Barriers.

On the state level, the Governor's Committee on Employment of the Handicapped reviewed Senate Bill 124, as enacted by the Ohio Legislature in 1965. The Committee expressed concern about the loopholes in the architectural barrier legislation.

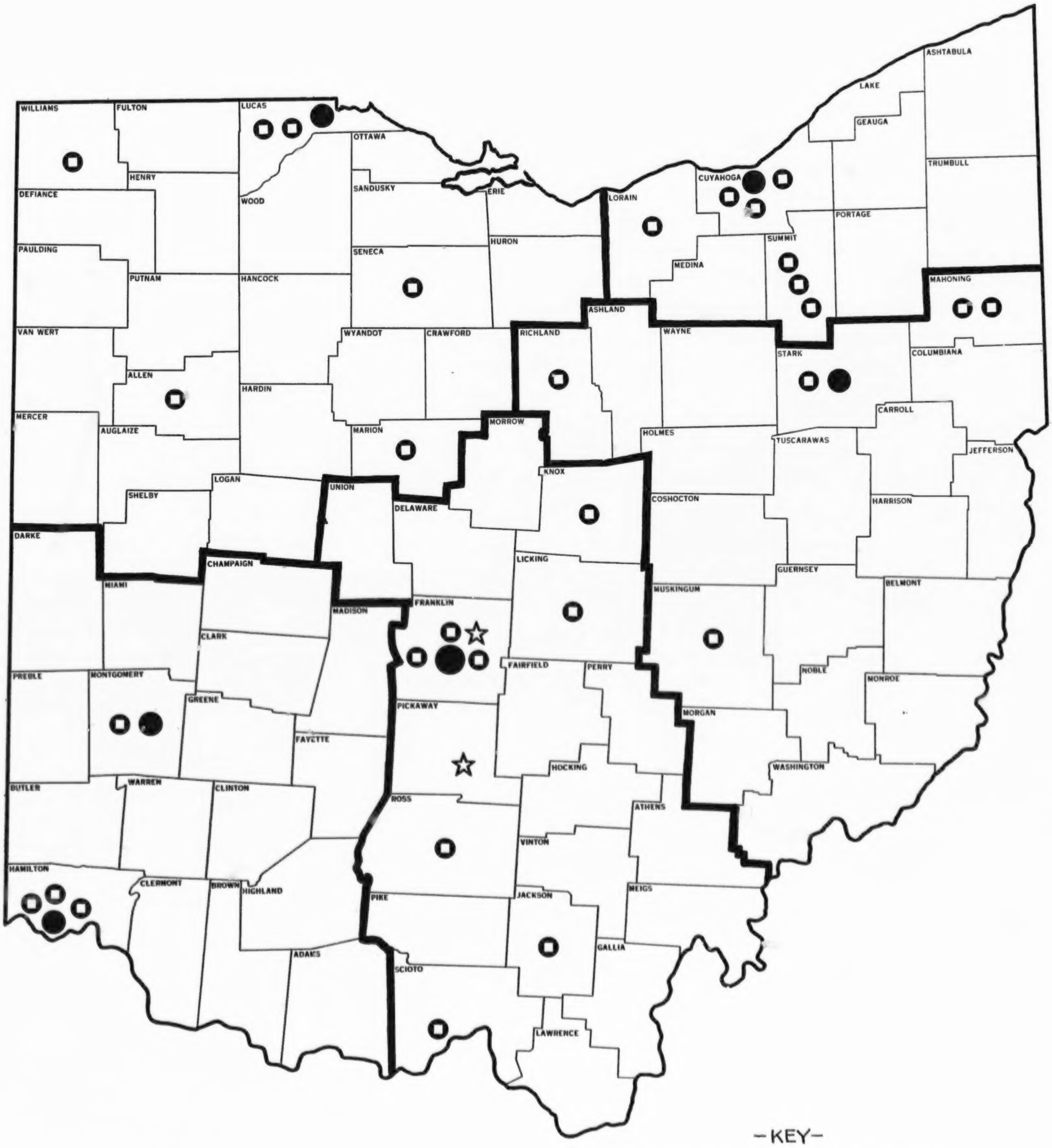
Architectural barriers, as they relate to Ohio college students, tend to reflect the following characteristics as of the spring quarter of 1968.

At the University of Illinois there were 68 wheel-chair students. Ten of these were from Ohio. BVR-Ohio had enrolled about 1,200 clients as students in institutions of higher education. Of these 1,080 are attending Ohio institutions, about 120 are attending out of state schools. The Ohio State University is considering a study to identify the number and nature of the handicapped students on its campus in Columbus.

One survey processed by the statewide planning staff indicated that the Ohio State University and Kent State University scored highest on this survey which included architectural barriers, terrain, and other related items in an attempt to identify Ohio institutions of higher learning in terms of adaptability for use by severely handicapped college students.

OHIO BUREAU OF SERVICES FOR THE BLIND

REGIONAL OFFICES AND SERVICE FACILITIES FOR THE BLIND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ERIE
LORAIN
CUYAHOGA
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VAN WERT
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CRAWFORD
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AUGLAIZE
MARION
MORROW
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MADISON
CLARK
PREBLE
MONTGOMERY
FAIRFIELD
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PICKAWAY
MORGAN
FAYETTE
HOCKING
WASHINGTON
BUTLER
WARREN
CLINTON
ROSS
ATHENS
VINTON
HAMILTON
CLERMONT
BROWN
HIGHLAND
PIKE
JACKSON
MEIGS
ADAMS
GALLIA
SCIOTO
LAWRENCE

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● REGIONAL OFFICES OF OBSB

○ FACILITIES OFFERING SERVICES TO THE BLIND

☆ STATE OPERATED FACILITIES AND UNITS

FIGURE 23

ASSESSMENT OF OHIO'S STATE REHABILITATION AGENCIES

A. Introduction[1]

1. Purpose and Scope

This report has been prepared by Harbridge House, Inc., for the Governor's Council on Vocational Rehabilitation as part of its Comprehensive Statewide Planning study of the needs, resources, and objectives in vocational rehabilitation for the period from FY 1967 to FY 1975. The report presents the results of our assessments of the two state agencies that have the primary responsibility for vocational rehabilitation in Ohio -- the Bureau of Vocational Rehabilitation in the Department of Education and the Bureau of Services for the Blind in the Department of Public Welfare.

In accordance with the terms of our contract with the Bureau of Vocational Rehabilitation and the Bureau of Services for the Blind, the purpose of the report is to provide recommendations for increasing the effectiveness of the two agencies. In the Bureau of Vocational Rehabilitation, our study concentrated on the general VR program; no specific analysis was made of the Social Security Disability Determination program. In the Bureau of Services for the Blind, our study concentrated on the VR program; no specific analysis was made of the other programs of the agency.

2. Method

The analyses set forth in this report are designed to focus attention, first, on the results that the agencies have achieved, and second, on the resources that the agencies have had at their disposal and the use that they have made of them. The analyses of results deal mainly with services to clients -- how many are served and how well they are served. They identify strengths and weaknesses of the agencies as these are reflected in such indicators as the relative distribution of types of disability among the agency caseloads and among the handicapped population of the state; the number of cases closed successfully; the effect of such factors as age, sex, education, and geographic location on the probability of successful rehabilitation; and the length of time between events in the cycle of referral, evaluation, service, and placement.

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[1] *Assessment of Agency Performance*, pp. I-1; I-2.

The analyses of resources deal with both financial and organizational resources. The analyses of financial resources are addressed to the adequacy of the agencies' funding and to the use that is made of the available funds, in terms of such indicators as the distribution of funds among the major categories of expenditure and the costs of case services and rehabilitated cases. The analyses of organizational resources deal with organization structure and deployment of personnel, distribution of authority and responsibility, acquistion and development of personnel, procedures for program review and control, relations with the legislature and the public, coordination and cooperation with other public and private agencies, and procedures for program planning and development.

B. The Bureau of Vocational Rehabilitation[1]

1. Introduction

This assessment of the Bureau of Vocational Rehabilitation is designed to answer the following questions.

How well has the BVR fulfilled its mandate to rehabilitate Ohio's eligible disabled population?

Do the results achieved meet the needs for service?

Does overall performance compare favorably — or unfavorably — with that of other state VR agencies?

Which aspects of the BVR's organization and operations contribute to program strengths and weaknesses?

---

[1] Assessment of Agency Performance, pp. IV-1 ff.

Are the organization structure and staffing adequate?

Are its management operations and procedures effective?

How should the organization and operations of the BVR be modified:

What changes should be made?

What new policies and procedures should be implemented?

2. Client Services and Expenditure Patterns

This section of the report presents our findings and analyses of the BVR's services to clients and expenditures pattern.

Client Services

a. Introduction

The following subsections present the result of a series of analyses designed to assess the patterns of service provided by the BVR. First, the disability "mix" is analyzed to determine the relation between the structure of the disabled population and the BVR caseload. Next, the caseload is analyzed in terms of geographic distribution, distribution by age, sex, and education and economic impact. Finally, caseload management and referral source data are reviewed.

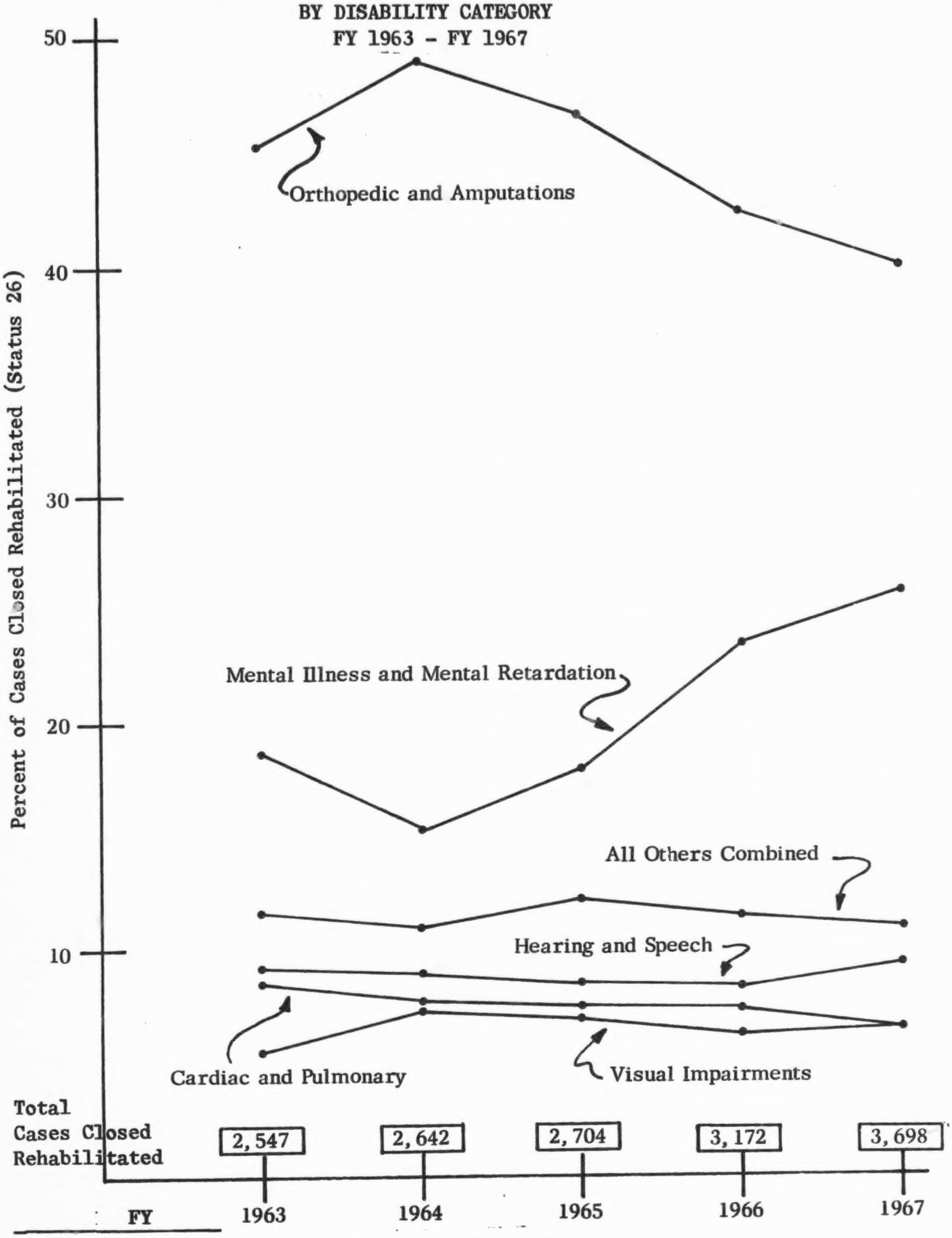
b. Disability Profile

The disability categories of clients served by the BVR include all major disabilities except legal blindness, which is discussed in "C. The Bureau of Services for the Blind."

Figure 24 shows the disability mix of cases closed rehabilitated by the BVR from FY 1963 to FY 1967. Throughout the five-year period, the BVR placed major emphasis on the rehabilitation of persons vocationally disabled by orthopedic injuries and amputations. Although the percent of

FIGURE 24 *

DISABILITY MIX OF CLIENTS REHABILITATED BY THE BVR
BY DISABILITY CATEGORY
FY 1963 - FY 1967



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* IV-1, Assessment of Agency Performance, p. IV-3.

orthopedic and amputation cases among total rehabilitations decreased from FY 1964 to FY 1967, the absolute number of the orthopedically disabled increased by 28 percent during the five-year period.

In view of the recent legislation (effective December, 1967) providing for the allocation of $80,000 a year to the BVR by the Industrial Commission -- to be matched 75:25 by Federal funds -- to pay for the cost of VR services to eligible Workmen's Compensation (WC) clients, orthopedic and amputation cases should contine to be the major class of rehabilitations. The BVR has a major incentive to serve more WC clients, since $320,000, as well as allowances for client maintenance, will be available annually for case services. In FY 1964 the Industrial Commission handled over 300,000 compensable occupational injury and disease cases (or 11 percent of all covered workers) costing $133 million, of which a substantial portion would be classified as orthopedic cases. Even if only 1 percent were eligible for VR services, the size of the demand would be considerable.

The increase in rehabilitations of the mentally ill and mental retardates from FY 1964 to FY 1967 represents a significant change in the BVR's disability profile. Unit programs connected with mental institutions and new outpatient facilities undoubtedly will produce further increases in rehabilitations in this disability category.

Over the five-year period, the percent of closed rehabilitated cases in all other disability categories remained relatively constant as a proportion of total rehabilitations, although the actual number of cases increased for each category.

c. Geographic Distribution

Geographic factors are important determinants of a disabled person's opportunity to be successfully rehabilitated. In Ohio, rehabilitation rates vary among regions. As shown in Table 17, the rehabilitation rate for Region IV was more than double that for Region II from FY 1964 to FY 1966. There are no readily apparent explanations for these variations. For example, Appalachia is divided between Regions IV and V; Region IV would not appear to present greater placement opportunity than the other regions. The BVR has never studied the reasons for differences in rehabilitation rates among regions. The Ad Hoc Task Force examined total encumbrances but not rehabilitation rates.

An in-depth analysis of the causes for geographic variation in vocational rehabilitation rates within Ohio was beyond the scope of this report. Table 17 does indicate that further study is warranted. Among the geographic factors to be considered are rural versus urban location, relative placement opportunities, severity levels as affected by age and education, prevalence of specific disabilities, and areas of marked poverty. Cost, budget, staffing, and counselor production patterns of the regions should be studied simultaneously.

TABLE 17 **

COMPARISON OF REHABILITATIONS PER 100,000
RESIDENTS OF SEVEN OHIO REGIONS--BVR--
FY 1963-FY 1967

Region	Fiscal Year				
	1963	1964	1965	1966	1967*
I (Toledo)	33	39	35	35	43
II (Cleveland)	18	15	17	21	20
III (Akron)	25	24	27	28	40
IV (Mansfield)	32	40	38	45	44
V (Columbus)	27	27	27	34	43
VI (Cincinnati)	21	20	21	26	30
VII (Dayton)	27	29	28	33	36
BVR Average	25	25	26	30	35

*Based on 1966 population estimates.

** IV-1, Assessment of Agency Performance, p. IV-4.

d. Age, Sex, and Educational Characteristics

Analysis of the age, sex, and educational characteristics of a VR agency's closed rehabilitated cases helps to determine whether the agency is serving all population groups adequately. The characteristics of the BVR's rehabilitated cases do not follow the national pattern; they indicate a high "screen rate" — that is, selection of the more easily rehabilitated from among referrals.

In judging the age characteristics of caseloads the strong correlation of age and disability should be considered. For example, chronic disabling conditions are six times more frequent among persons 65 years old and over than among those under 65. Age is also a determinant of placement, and therefore, vocational potential. For males, the labor force participation rate is highest (and relatively level) in the 25 through 54 age group. For females, the labor force participation rate is highest in the 45 through 54 age group.

In FY 1966 the median age of BVR rehabilitants was 29, four years lower than the U.S. median age -- 33 -- for rehabilitants. These medians reflect a larger percentage of young people in the BVR caseloads: 67.6 percent of the BVR's rehabilitants, as opposed to 53.8 percent of U.S. rehabilitants, were under 35 years. Within the group 35 and over, the BVR's emphasis on rehabilitating younger clients than the U.S. pattern became more pronounced: it rehabilitated half the U.S. proportion in the 55 and over age group. The BVR's client selection process does not appear to give adequate weight to the heavy labor force population rate in the age bracket 45-54 for both men and women.

The BVR rehabilitates a larger proportion of males than the national average. In FY 1966 only 25 percent of BVR rehabilitants were female, as opposed to their 40 percent representation among U.S. rehabilitants. There appears to be a gradual national trend toward a 50:50 male-female caseload. The U.S. female population outnumbers the male and is becoming increasingly important in the labor force. In 1965 women made up one-third of the labor force in addition to filling their basic homemaking role.

BVR rehabilitants have attained higher educational levels than the national level for rehabilitants. In FY 1966, 57 percent of Ohio rehabilitants had an eleventh grade or higher education as opposed to the national pattern of only 42 percent. In FY 1966, 22.5 percent of the BVR's closed rehabilitated cases, as opposed to 39 percent of U.S. closed rehabilitated cases, had attained only an eighth grade or lower educational level. Within the eighth grade or lower group, U.S. rehabilitants had less education than BVR rehabilitants: 5 times as many had no education and 4.4 times as many had only one to four years of schooling. The BVR does not appear to be reaching the hard-core unemployed as well as other VR agencies are.

e. Earnings and Family Characteristics

The "Return on Investment" to the whole economy from the vocational rehabilitation of disabled citizens is an important measure of the efficacy of a VR program. Table 18 analyzes the earning of BVR rehabilitants before and after service. The FY 1967 jump in rehabilitants earning wages of more than $40 before service may reflect an increase in Workmen's Compensation cases. The increase in the proportion of clients earning more than $40 after rehabilitation indicates improved placement practices and that counselors are not "settling" for homemaker placements. However, the lack of improvement in the proportion of rehabilitants (in fact, a numerical increase from 200 to 323 rehabilitants) with no income after service may indicate that the BVR is not helping the hard-core disabled adequately. Further investigation of this group to determine how many are homemakers and how many are "unsuccessful rehabilitants" appears warranted.

One consequence of the Ohio BVR's emphasis on rehabilitation of younger clients is that a lower proportion of BVR clients have dependents than the national average. A high proportion of rehabilitants without dependents has a smaller economic impact than a high proportion of rehabilitants with dependents, since larger welfare and disability insurance payments are paid to heads of families than to single persons. The proportion of BVR rehabilitants with dependents decreased from 43.5 percent of cases closed rehabilitated in FY 1963 to 38.4 percent in FY 1966.

During the same period, the national proportion of rehabilitants with dependents to total rehabilitants decreased from 46.8 percent to 43.9 percent.

TABLE 18*

EARNINGS OF BVR REHABILITANTS (STATUS 26)
BEFORE AND AFTER SERVICE
FY 1963-FY 1967

		Fiscal Year			
	1963	1964	1965	1966	1967
Before Rehabilitation					
No earnings	82.8%	86.8%	85.7%	86.7%	81.5%
Under $40	9.0	4.1	4.8	4.8	5.0
$40 and over	8.2	9.1	9.5	8.5	13.5
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
After Rehabilitation					
No earnings	7.9%	7.9%	9.2%	7.2%	8.7%
Under $40	24.0	19.0	17.6	13.4	10.5
$40 and over	68.1	73.1	73.2	79.4	80.8
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
Total Number of Cases	2,547	2,642	2,704	3,172	3,698

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* IV-2, Assessment of Agency Performance, p. IV-7.

f. Counselor Performance and Caseload Processing

Despite staff increases, in FY 1967 the BVR still had an inadequate number of counselors to serve the state's rehabilitation needs. Table 19 compares counselor per population ratios for the BVR, RSA Region V, and the country. (BVR counselors in training were not included in determining these ratios.) Projected staff increases would reduce the total number of residents per counselor to 56,000 by FY 1969. However, the BVR's current fiscal crisis makes attainment of this objective appear doubtful.

TABLE 19 *

COMPARISON OF COUNSELOR/POPULATION RATIOS FOR THE
BVR, RSA REGION V, AND THE UNITED STATES
FY 1966-FY 1967

	Total Number of Residents per Counselor Man-Year	
Location	FY 1966	FY 1967
BVR	183,000	108,000
RSA Region V	86,000	NA
United States	58,000	NA

The actual number of cases rehabilitated per counselor began a sharp decline in FY 1966, as shown in Table 20. There is, of course, a substantial time lag between the employment and training of a counselor and the rehabilitation of clients. Assignment of counselors to specialized units (cooperative projects in state institutions) with smaller caseloads than those in the BVR's district offices further reduced the impact of the staff increase.

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* IV-3, Assessment of Agency Performance, p. IV-8.

TABLE 20 *

BVR CASELOAD STATISTICS
FY 1963 - FY 1967, with Projections to FY 1969

Fiscal Year	(1) Cases Accepted	(2) Caseload Served	(3) Cases Rehabilitated	(4) Number of Counselors	(5) Rehabilitated per Counselor Man-Year
1963	3, 550	8, 710	2, 547	52	48.7
1964	3, 676	8, 731	2, 642	48	52.2
1965	3, 488	8, 551	2, 704	52	51.3
1966	4, 839	9, 761	3, 172	85	54.5
1967	6, 686	12, 466	3, 698	166	37.2
1968 (Est.)	9, 056	16, 850	5, 000	196	30.0
1969 (Est.)	9, 508	26, 358	5, 750	231	28.0

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* IV-4, Assessment of Agency Performance, p. IV-9.

The efficacy of a VR agency is related to the proportion in its total caseload of referrals and applicants who refused rehabilitation or were rejected for other reasons before receiving any service. Figure 25, a schematic diagram of the BVR's caseload flow for FY 1967, indicates that in addition to serving the active caseload, counselors processed 6,222 referrals to applicant status (including 293 undergoing extended evaluation), 6,686 applicants to active case statuses, and closed 6,501 referral and applicant cases without any substantial service (before client plan approval).

The primary use of the caseload flow diagram is measurement of the promptness with which the BVR delivers its services and the extent of "inventory pile-ups". An excessive VR caseload is difficult to manage, is costly in terms of professional time, and "spoils" as clients lose their motivation through delays.

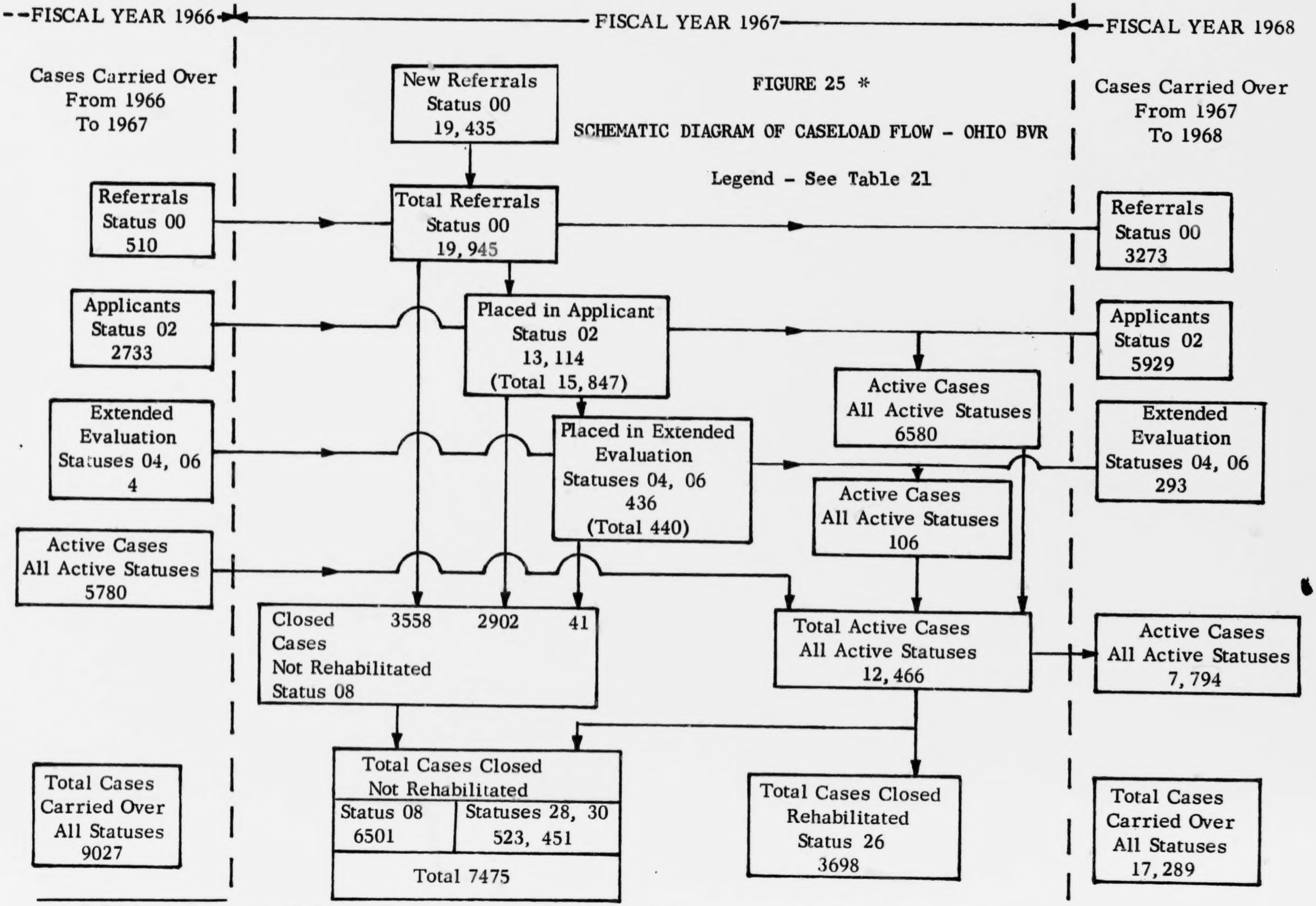
Analysis of the FY 1967 caseload flow diagram indicates that from July 1, 1966 to July 1, 1967, total inventory increased by 91.5 percent; active case inventory, by 34.8 percent, and total referral and applicant inventories, by 192.4 percent. Furthermore, there appears to be a built-in time lag which contributes to "shortage". In terms of the number of referrals received during FY 1967 (19,435), the year-end referral inventory (3,273) would represent approximately 2.0 months of referral intake (assuming an even flow of referrals throughout the year). On this same basis the year-end applicant inventory (5,929 applicants) would represent an additional 3.7 months of referral intake.

A high proportion of nonrehabilitated closures (Status 08) to case acceptances indicates a high screening rate. Will the BVR's screening rate automatically become higher in FY 1968 and FY 1969 as new counselors achieve full caseloads? The records of the 10 BVR counselors with the highest production of rehabilitants in FY 1967 indicate that in only two cases does the ratio of Status 08 closures to total clients screened (case acceptances and Status 08 closures) exceed 50 percent. The average rejection rate is 41.9 percent and the median in the 42.2 to 46.6 percent range, with a low of 22.9 percent and a high of 55.3 percent.

FIGURE 25 *

SCHEMATIC DIAGRAM OF CASELOAD FLOW - OHIO BVR

Legend - See Table 21


--FISCAL YEAR 1966
FISCAL YEAR 1967
FISCAL YEAR 1968
Cases Carried Over From 1966 To 1967
Referrals Status 00 510
Applicants Status 02 2733
Extended Evaluation Statuses 04, 06 4
Active Cases All Active Statuses 5780
Total Cases Carried Over All Statuses 9027
New Referrals Status 00 19,435
Total Referrals Status 00 19,945
Placed in Applicant Status 02 13,114 (Total 15,847)
Placed in Extended Evaluation Statuses 04, 06 436 (Total 440)
Closed Cases Not Rehabilitated Status 08
3558
2902
41
Total Cases Closed Not Rehabilitated
Status 08 6501
Statuses 28, 30 523, 451
Total 7475
Active Cases All Active Statuses 6580
Active Cases All Active Statuses 106
Total Active Cases All Active Statuses 12,466
Total Cases Closed Rehabilitated Status 26 3698
Cases Carried Over From 1967 To 1968
Referrals Status 00 3273
Applicants Status 02 5929
Extended Evaluation Statuses 04, 06 293
Active Cases All Active Statuses 7,794
Total Cases Carried Over All Statuses 17,289

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* IV-2, Assessment of Agency Performance, p.IV-10.

TABLE 21 *

REVISED RSA STATUSES LEGEND FOR FIGURE 25 (SCHEMATIC DIAGRAM OF CASELOAD FLOW--OHIO BVR)

Status	
00	Referral
02	Applicant
04	Six-Month Extended Evaluation
06	Eighteen-Month Extended Evaluation
08	Closed After Referral--from Statuses 00, 02, 04, or 06
10	Plan Development
14	Counseling and Guidance Only
16	Physical Restoration
18	Training
20	Ready for Employment
26	Closed Rehabilitated
28	Closed Not Rehabilitated After Rehabilitation Plan Initiated
30	Closed Not Rehabilitated Before Rehabilitation Plan Initiated

g. Referral Sources

Table 22 analyzes referral sources for cases closed rehabilitated by the BVR from FY 1963 to FY 1967. The dominant trends were an increase in the proportion of referrals from educational institutions and the state employment service and a decline in the proportion of referrals from other health agencies (rehabilitation centers, state and local public health agencies, and so forth).

Nationally, during the FY 1963-66 period, referrals from educational instututions increased from 12.3 percent to 14.1 percent of rehabilitations, and state employment service referrals decreased from 6.2 percent ot 5.7 percent; the proportion of referrals from other health agen-

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* IV-5, Assessment of Agency Performance, p. IV-11.

cies decreased from 6.1 percent to 5.6 percent. Also of interest is an FY 1963-66 national decline in referrals from physicians from 15.5 percent to 13.8 percent; BVR referrals from physicians remained relatively stable, but at a much lower level, over the same period.

TABLE 22 * *

SOURCES OF REFERRALS FOR BVR CASES
CLOSED REHABILITATED (STATUS 26)
FY 1963-FY 1967

Source	Fiscal Year				
	1963	1964	1965	1966	1967
Educational Institutions	16.0%	16.8%	17.9%	20.1%	20.1%
Hospitals	15.2	12.2	12.8	14.2	14.4
Other Health Agencies	11.2	9.7	10.2	9.1	8.5
Physicians	6.2	7.2	8.2	6.7	6.3
Social Security Administration and Workmen's Compensation*	7.4	7.3	6.4	5.9	6.5
Welfare	9.1	9.7	9.5	8.9	7.4
State Employment Service	8.6	10.2	8.2	10.4	12.3
Family and Friends	8.7	10.0	10.3	9.2	9.0
Self	7.6	6.8	7.0	7.4	6.6
All Other	9.9	10.2	9.6	8.0	9.1
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL REHABILITATIONS	2,547	2,642	2,704	3,172	3,698

*In FY 1967 Workmen's Compensation referred 2.7 percent of the cases closed rehabilitated.

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* * IV-6, Assessment of Agency Performance, p. IV-13.

Expenditure Patterns

a. Introduction

The BVR's use of available funds is reviewed below. Our analysis covers the distribution of funds among the major categories of expenditure, the costs of case services and rehabilitated cases, the case services budget per counselor, and the effect of geographic location on expenditures.

b. Operating Budget

Administration, Guidance and Placement, and Case Services are the three expense classes in the Section 2 VR budget.* Administration covers the Director's salary and other costs of operating the State Office. Guidance and Placement includes the salaries and overhead costs of all counselors and field supervisors; and Case Services, the monies expended directly on behalf of clients. As with all accounting classifications, they are arbitrary and can be deceiving. Nevertheless, some useful observations can be made about their interrelationships in Ohio.

Figure 26 presents a five-year historical profile, and projections to 1969, of these expenditure categories as a percent of the Section 2 budget. The dominant long-term trends are a decline in the proportion and the amount of Case Services' share of the total budget and a concomitant increase in Guidance and Placement, reflecting a rapid growth in the counseling staff. The average case services expenditure per client (rehabilitated and non-rehabilitated) had already declined significantly: from $148 in FY 1963 to $136 in FY 1966. During the same period, the U.S. average case services expenditure per client increased from $136 to $163.

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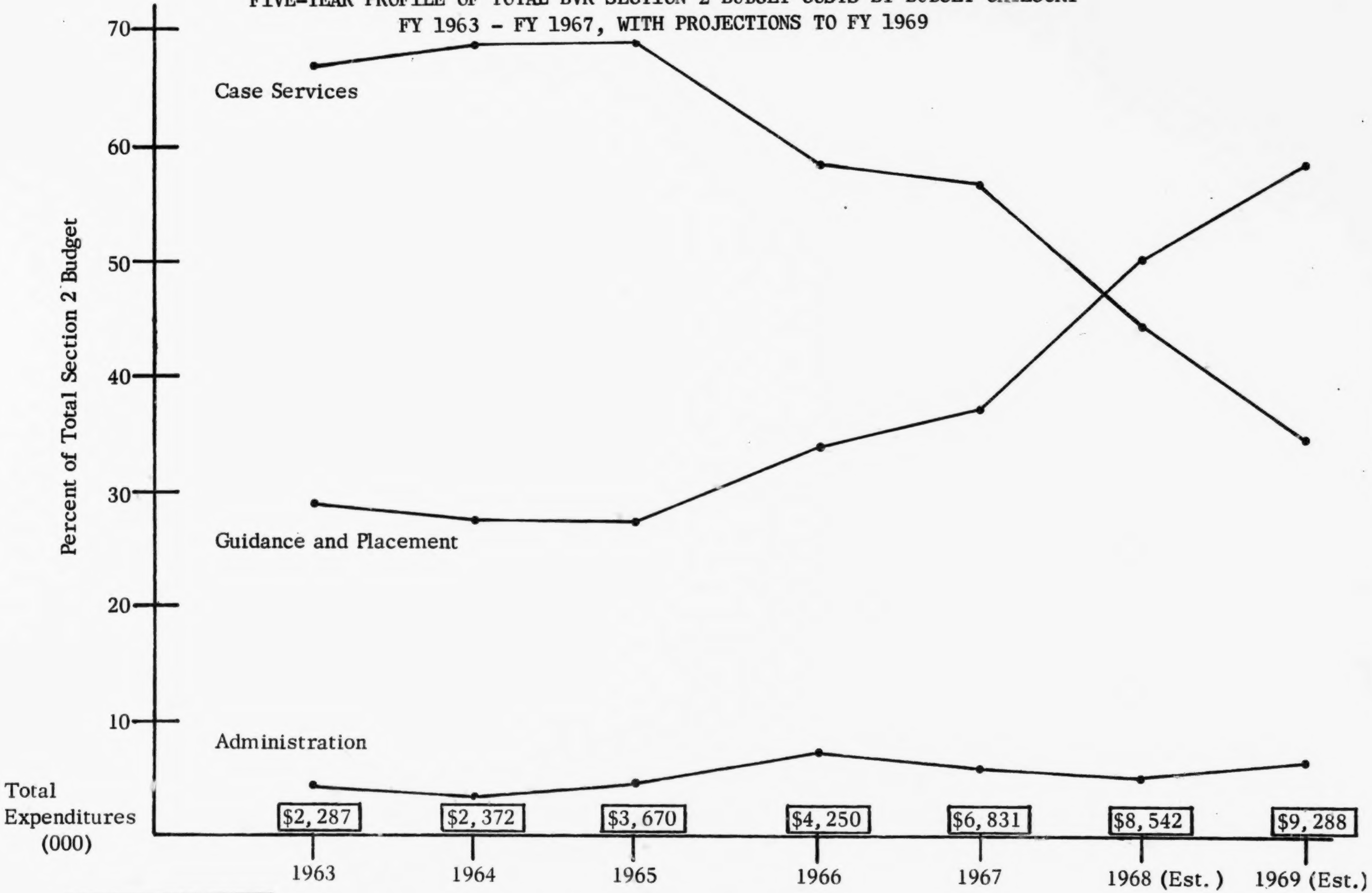
* This Section 2 budget is that portion of total agency budget which incorporates all costs for services -- the costs of the State Office, the counseling staff, and vendor expenses.

FIGURE 26*

FIVE-YEAR PROFILE OF TOTAL BVR SECTION 2 BUDGET COSTS BY BUDGET CATEGORY
FY 1963 - FY 1967, WITH PROJECTIONS TO FY 1969



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* IV-3, Assessment of Agency Performance, p. IV-17.

c. Costs of Case Services

Five main groups of case services are offered to clients of the BVR:

Diagnosis -- medical and nonmedical.

Treatment -- surgery and physiotherapy, the provision of prostheses, and hospital and convalescent care.

Rehabilitation and adjustment -- primarily prevocational training and social adjustment services offered by rehabilitation facilities.

Work preparedness -- training and training materials; tools, equipment, and licenses; and other.

Maintenance and transportation -- allowances to clients in training.

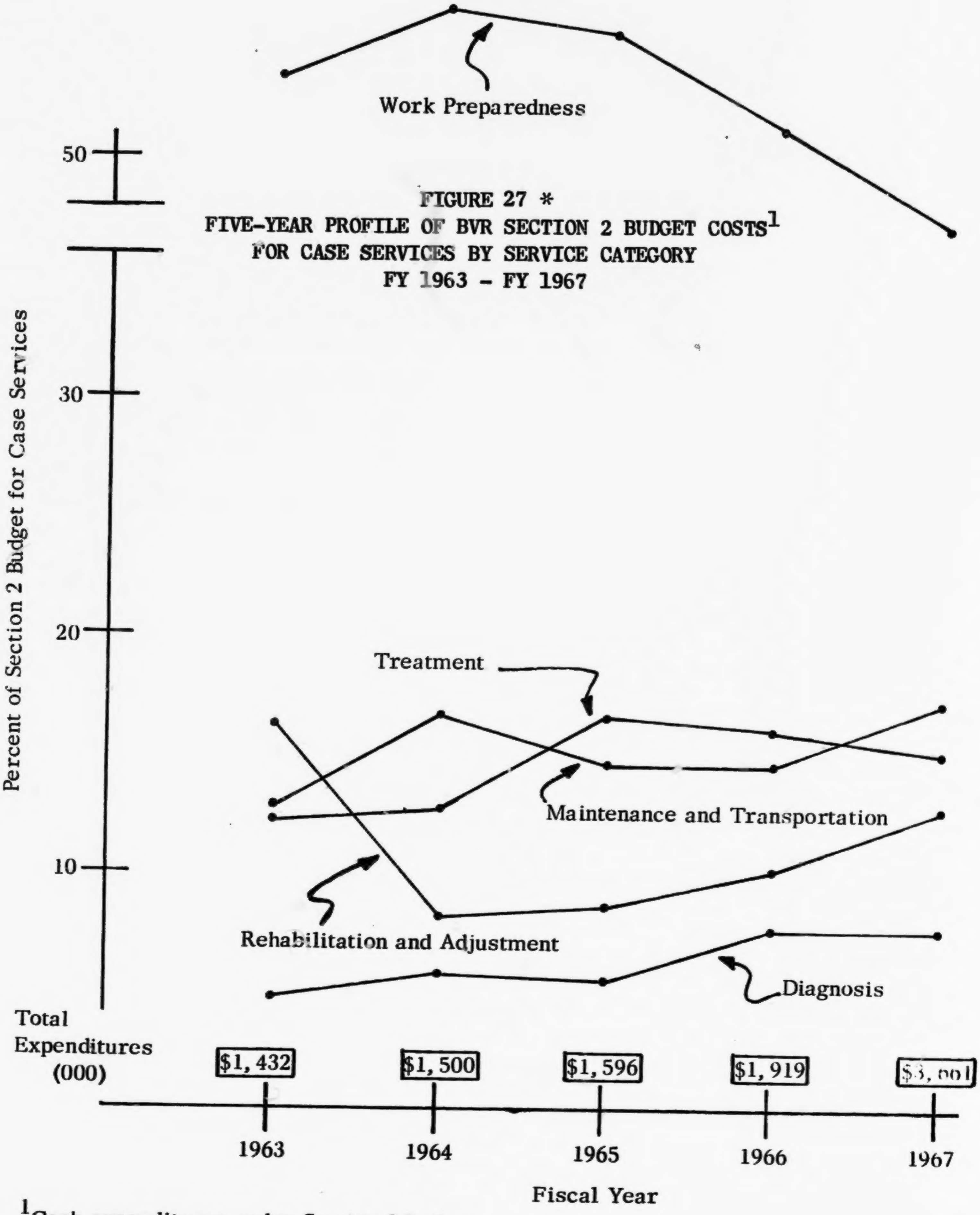
The BVR purchases most of these case services from vendors, both local and out-of-state. Figure 27 shows the patterns of expenditure for Case Services in the period FY 1963 to FY 1967. The most significant trend in case services expenditures was a proportionate decrease in work preparedness; total dollar expenditures for this category, however, doubled from FY 1965 to FY 1967. Comparison of Ohio and national average expenditures per client (rehabilitated and nonrehabilitated) indicate that Ohio's patterns are atypical.

From FY 1963 to FY 1966 the U.S. average cost of maintenance and transportation per client rose from $211 to $229. In Ohio, maintenance and transportation costs per client -- already 9 percent higher than the national average -- rose from $228 to $298 during the same period.

The average U.S. cost of treatment per VR client rose from $171 to $205 from FY 1963 to FY 1966. During the same period, the comparable average cost in Ohio rose from $227 to $328 and to $359 in FY 1967.

The BVR's average expenditure per client in rehabilitation and adjustment centers declined from $164 to $156 from FY 1963 to FY 1966, whereas the U.S. average

FIGURE 27 *
FIVE-YEAR PROFILE OF BVR SECTION 2 BUDGET COSTS[1]
FOR CASE SERVICES BY SERVICE CATEGORY
FY 1963 - FY 1967



[1] Cash expenditures under Section 2 budget.

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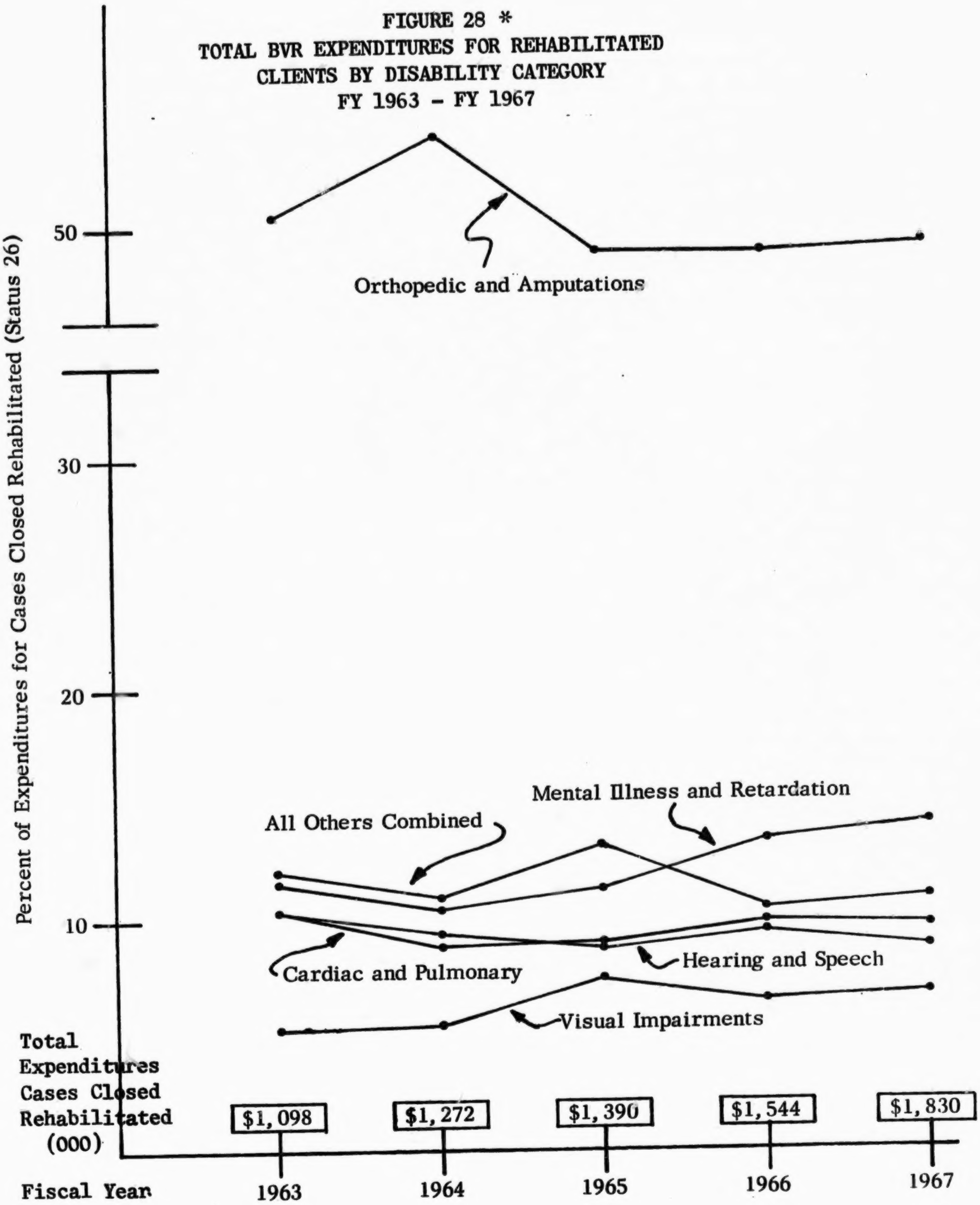
* IV-4, Assessment of Agency Performance, p. IV-17.

FIGURE 28 *
TOTAL BVR EXPENDITURES FOR REHABILITATED CLIENTS BY DISABILITY CATEGORY
FY 1963 - FY 1967



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* IV-5, Assessment of Agency Performance p. IV-18.

climbed from $438 to $560. Expenditures in workshops are not included in these averages. Ohio did not make any significant expenditures in workshops. The average U.S. expenditure in workshops rose from $295 to $346 during the same period.

d. Costs of Rehabilitated Cases

In FY 1966 the average case services expenditure per rehabilitation for the United States ($518) was 6.4 percent higher than the average for Ohio ($487). Figure 28 breaks down total expenditures (from date of referral to closure) for all cases closed rehabilitated from FY 1963 to FY 1967 by type of disability. Comparison with Figure 24, which analyzed the distribution of closed cases, reveals a startling difference between the expenditure and case frequency patterns for two disability categories: mental illness and mental retardation, and orthopedic and amputations.

The decline of orthopedic cases from 46.8 percent in FY 1965 to 40.0 percent in FY 1967 of total cases closed rehabilitated is not reflected in the very slight increase in orthopedic expenditures from 49.0 percent to 49.3 percent of total closed case expenditures over the same period. Table 23 shows that average costs per rehabilitant for orthopedic and amputation cases rose by more than 26 percent from FY 1963 to FY 1967, as opposed to an increase of about 15 percent for all categories in the same period. The $320,000 in funds now to be allocated specifically for Workmen's Compensation cases (largely orthopedic) should exert a dampening effect on the trend toward increased orthopedic rehabilitation costs. Workmen's Compensation will also pay maintenance costs for these cases.

Expenditures for rehabilitants with mental illness and mental retardation, on the other hand, increased far less rapidly than did their number and proportion among total BVR closed cases from FY 1964 to FY 1967. As shown in Table 24 , further analysis indicates that, within this total, a decline in costs per rehabilitation for the mentally ill was the cause of the differential. Table 24 also shows that costs per rehabilitation for the mentally ill decreased by 25.7 percent from FY 1964 to FY 1967, while costs per rehabilitation for the mentally retarded increased

TABLE 23 *
THE BVR'S AVERAGE EXPENDITURE PER REHABILITANT BY DISABILITY CATEGORY CASES CLOSED REHABILITATED (STATUS 26)
FY 1963-FY 1967

	Fiscal Year				
Disability Category	1963	1964	1965	1966	1967
Orthopedic and Amputation	$481	$536	$544	$572	$609
Mental Retardation	215	180	212	197	254
Mental Illness	296	377	377	323	280
Cardiac and Pulmonary	521	540	609	632	718
Hearing and Speech	475	493	533	542	471
Visual Impairments	389	372	573	513	509
All Others Combined	440	482	557	450	484
BVR AVERAGE	$431	$481	$514	$487	$494

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* IV-7, Assessment of Agency Performance, P. IV-20.

TABLE 24 **

MENTAL ILLNESS AND MENTAL RETARDATION--
COMPARISON OF PROPORTIONS IN TOTAL BVR
REHABILITATIONS AND EXPENDITURES
FY 1964-FY 1967

	% of Closed Cases		% of Expenditures	
	FY 1964	FY 1967	FY 1964	FY 1967
Mental Illness	10.1	15.7	8.8	8.9
Mental Retardation	4.4	10.2	1.6	5.3
TOTAL	14.5	25.9	10.4	14.2

41 percent over the same period.

This downward trend in costs for the mentally ill is not expected to continue. In 1967 the average costs per rehabilitation for the mentally ill was more than $440 for the United States as a whole, as opposed to $280 for the Ohio BVR. The merger of the BVR and the BSB with the Department of Mental Hygiene and Corrections, should produce a natural increase in awareness of the needs of mental health patients. However, in FY 1967 the Ohio BVR was already placing major emphasis on rehabilitation of institutionalized patients.* Current plans include the rehabilitation of outpatients, resulting in increased costs for longer, more intensive therapy. Costs are also expected to continue to increase for mental retardates as

* Staff physicians and other professionals in institutions charge only direct time to VR projects rather than total salary. Use of this time-study, cost accounting method results in lower service costs than would obtain in outside institutions.

** IV-8, Assessment of Agency Performance, p. IV-21.

more severe clients and outpatient clients are rehabilitated. (In FY 1967 the average cost per retarded rehabilitant was only $254 in Ohio, as opposed to $457 for the national average.)

e. Case Services Budget per Counselor

The decline in the anticipated case services budget per counselor, shown in Table 25 , indicates a substantial decline in counselor productivity as a result of the rapid increase in new and inexperienced counselors from FY 1966 to FY 1967.

TABLE 25*

BVR CASE SERVICES PER COUNSELOR
FY 1963-FY 1967, With Projections to 1969

Fiscal Year	Cases Rehabilitated	Number of Counselors	Rehabilitations per Counselor	Case Services Budget per Counselor
1963	2,547	52	48.7	$29,289
1964	2,642	48	52.2	32,215
1965	2,704	52	51.3	33,039
1966	3,172	85	54.5	37,390
1967	3,698	166	37.2	36,789
1968 (Est.)	5,000	196	30.0	21,701
1969 (Est.)	5,750	231	28.0	14,684

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* IV-9, Assessment of Agency Performance, p. IV-22.

f. Effect of Geographic Location on Expenditures

While Table 26 shows distinct geographic variations in case services expenditures per rehabilitant from FY 1963 FY 1966, these variations do not correlate absolutely with the variations in rehabilitation rates per 100,000 residents shown in Table 17 . Costs not only vary widely from region to region in any given year, but within regions from year to year. Region IV, however, does show a consistently high rate of expenditures per rehabilitation, and Region II a generally low rate in relation to the other regions.

TABLE 26 *

AVERAGE BVR CASE SERVICES EXPENDITURES PER REHABILITATION BY REGION
FY 1963-FY 1966

Region	Fiscal Year			
	1963	1964	1965	1966
I (Toledo)	$396	$452	$574	$552
II (Cleveland)	288	420	399	428
III (Akron)	429	573	559	511
IV (Mansfield)	615	548	646	642
V (Columbus)	390	494	462	360
VI (Cincinnati)	546	458	491	508
VII (Dayton)	404	407	469	422
BVR AVERAGE	$431	$481	$514	$487

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* IV-10, Assessment of Agency Performance, p. IV-23.

TABLE 27 *
BREAKDOWN OF TOTAL BVR CASE SERVICES EXPENDITURES BY REGION
FY 1967

Region	Expenditure					Total Expenditures per Region
	Diagnosis	Physical Restoration	Training and Materials	Maintenance and Transportation	All Others Combined	
I (Toledo)	$ 57, 091	$ 60, 110	$ 361, 125	$ 70, 833	$12, 753	$ 562, 012
II (Cleveland)	91, 524	55, 392	221, 407	70, 549	5, 770	444, 642
III (Akron)	106, 784	146, 130	425, 792	145, 898	9, 991	834, 595
IV (Mansfield)	52, 264	117, 718	223, 810	115, 970	6, 521	516, 283
V (Columbus)	92, 948	67, 982	178, 160	63, 505	6, 286	408, 881
VI (Cincinnati)	59, 718	68, 477	192, 953	85, 378	2, 211	408, 737
VII (Dayton)	71, 004	84, 929	236, 257	88, 230	10, 670	491, 090
TOTAL CASE SERVICES EXPENDITURES	$531, 333	$600, 738	$1, 839, 504	$640, 463	$54, 202	$3, 666, 240

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* IV-11, Assessment of Agency Performance, p. IV -24.

Table 27, which presents a categorical breakdown of case services expenditures by region for FY 1967, does indicate that Region IV may emphasize rehabilitation of orthopedic amputation cases at facilities outside the area, resulting in a higher proportion of expenditures for physical restoration and maintenance and transportation. Other variations are not too informative. For example, the significance of the high proportion of diagnostic expenditures in Regions II and V cannot be determined without analysis of the disability incidence and caseload mix in those areas.

C. The Bureau of Services for the Blind[1]

1. Introduction

This assessment of the Bureau of Services for the Blind, is designed to answer the following questions.

How well has the BSB fulfilled its mandate to rehabilitate Ohio's eligible legally blind population?

Do the results achieved meet the needs for service?

Does overall performance compare favorably -- or unfavorably -- with that of other state agencies rehabilitating the legally blind?

Which aspects of the BSB's organization and operations contribute to program strengths and weaknesses?

Are the organization structure and staffing adequate?

Are its operations and procedures effective?

How should the organization and operations of the BSB be modified?

What changes should be made?

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[1] Assessment of Agency Performance, pp. V-1 ff.

What new policies and procedures should be implemented?

2. Client Services and Expenditure Patterns

This section of the report presents our findings and analysis of the BSB's services to clients and its expenditure patterns.

Client Services

a. Introduction

The following subsections present the results of a series of analyses designed to assess the patterns of service provided by the BSB. First, the incidence of legal blindness, rehabilitation rates, and the prevalence of secondary disabilities are examined to determine the extent to which the BSB meets the needs of the disabled population. Next, the caseload is analyzed in terms of its geographic distribution; its age, racial, sex, and educational characteristics; economic impact; and reasons for nonrehabilitation. Finally, caseload management and referral source data are reviewed.

b. Disability Profile

Two basic factors determine whether a VR agency is adequately serving a disabled population: the proportion of client rehabilitations to incidence and the extent of its service to the more seriously disabled.

Prevalence and Rehabilitation Rate

The State of Ohio, which was estimated to have 20,000 legally blind residents in FY 1960, experienced a 10 percent growth in population by FY 1966. The gross annual replacement rate estimated in FY 1960 was 2,000; population growth brings this rate to 2,200 in FY 1966. Since these estimates are for the legally blind only, a reasonable assumption is that all but those previously rehabilitated by the BSB or other agencies are vocationally handicapped. In FY 1967 the BSB rehabilitated 278 persons, or only 12.6 percent of the adjusted annual replacement rate (2,200).

The BSB's rehabilitation rate per 100,000 population also compares unfavorably with the U.S. average:

FY	U.S. Average	BSB
1963	3.25	2.19
1967	4.68	2.70

The BSB's rehabilitation rate per 100,000 population increased only by 23.3 percent (in comparison with the U.S. increase of 44.0 percent) from FY 1963 to FY 1967.

Furthermore, the BSB has shown a marked increase in the percent of referrals which have been closed without rehabilitation (Status 08): from 33.5 percent in FY 1964 to 50.4 percent in FY 1967. The percentage of nonrehabilitants is expected to increase to 57.0 percent in FY 1968.

Even with a 60 percent screening rate, the BSB should be rehabilitating some 880 persons per year. The BSB certainly appears to be failing to reach and rehabilitate the eligible legally blind and vocationally handicapped population.

Secondary Disabilities

The Ohio BSB's caseload includes only residents who are legally blind in both eyes. (The visually impaired are rehabilitated by the BVR.) The medical severity of individual cases accepted for rehabilitation does, however, vary with secondary disabilities. Since medical records are not available for cases closed not rehabilitated before service (Status 08), no estimate can be made of the prevalence of secondary disabilities among referrals.

However, according to Table 28 , the incidence of secondary disabilities was higher (7.7 percent) among cases closed not rehabilitated after acceptance into the active caseload (Statuses 28 and 30) than among cases closed rehabilitated (Status 26) in FY 1967. (Diabetes is included because it has other disabling effects, although it is also a cause of blindness.) Both rehabilitated and nonrehabilitated groups are too small for any statistically valid comparison of subcategories. However, the incidence of diabetes, hypertension, and alcoholism appears to be slightly higher among the nonrehabilitated, while incidence of hearing impairment, personality disorders, and mental retardation appears slightly higher among the rehabilitated.

The BSB does not appear to be serving the more severely disabled blind. Subtracting diabetes, the proportion of truly secondary disabilities (24.1 percent) among its rehabilitations is low. The BSB's poor showing in this area may be related to the high correlation between age and disability. The average age of BSB rehabilitants (38) is six years lower than the U.S. average for rehabilitants (44). Furthermore, the BSB has participated in only one special project -- rehabilitation of mental retardates at Orient State -- designed specifically to seek out and serve blind groups with secondary disabilities.

c. Geographic Distribution

Review of the BSB's closed case distribution shows that geographic coverage is inadequate. The BSB's five district offices are located in Columbus, Cincinnati, Canton, Cleveland, and Toledo; and its single branch office, in Dayton. Blind persons who need rehabilitation generally have not developed sufficient mobility skill to travel any great distance, and lengthy trips are generally too time-consuming and too costly for companions. (The BSB has only six home teachers, who train in indoor-mobility skills, and no outside-mobility teachers -- peripatologists and mobility technicians.) The low mobility of the blind has effectively limited BSB service to clients living within a 50-mile radius of its district offices. The small size of the branch office's staff has further reduced its coverage to within a 25-mile radius.

TABLE 28 *
COMPARISON OF SECONDARY DISABILITIES
CASES CLOSED BY BSB AFTER ACCEPTANCE
FY 1967

Secondary Disabilities	Cases Closed Rehabilitated (Status 26)	Cases Closed Not Rehabilitated After Acceptance (Statuses 28 and 30)
Alcoholism	0.4%	3.0%
Diabetes	7.9	10.4
Hearing Impairment	3.9	1.5
Heart Condition	2.2	3.0
Hypertensive Disease	-	3.0
Personality, Inadequate/ Disordered	3.6	1.5
Loss of Extremity/ies	2.9	3.0
Mental Retardation	2.2	-
Multiple Sclerosis	1.4	3.0
Other	7.5	11.9
Total with Secondary Disabilities	32.0%	40.3%
Total with No Secondary Disabilities	68.0%	59.7%
TOTAL	100.0%	100.0%
NUMBER OF CASES	278	67

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* IV-1, Assessment of Agency Performance, p. V-4.

TABLE 29 **

AGE DISTRIBUTION* OF BLIND RESIDENTS

Ohio BSB Rehabilitations,
FY 1963-FY 1967

	AGE DISTRIBUTION				
Fiscal Year	Under 20	20-34	35-44	45-64	65 and over
1963	13.1	28.1	18.1	33.0	7.7
1964	11.9	21.8	19.2	44.6	2.6
1965	13.2	26.7	16.0	39.9	4.1
1966	20.5	22.8	20.5	30.2	4.9
1967	16.9	27.7	16.5	34.9	3.6

National Society for
the Prevention of Blindness
(National Estimates)

	Under 20	20-39	40-64	65 and over
1962	9.8	13.5	29.5	47.2

* Age distribution percentages are based on occurence within the total population.

** V-2, Assessment of Agency Performance, p. V-6.

Demarcation of BSB service areas on an Ohio map shows gaps. For example, the south eastern sector of Ohio, which includes the Appalachian region, is basically unserved. The territories between Mansfield and Lima and west of Lima along the Indiana border are also unserved. A smaller sector running from Lake Erie and Ashtabula along the Pennsylvania border to Youngstown is closer to BSB offices than the other uncovered areas. Even a cursory glance at a map indicates that offices could be established in Youngstown, Lima, Portsmouth, and Zanesville. Although Akron appears on a geographic basis to be served by Cleveland and Canton, manifest demand, already demonstrated, indicates that this city could supply enough clients to justify a district office. As noted in " h. Counselor Performance", quantity and quality of counselor service varies with location. Refer to Figure 23.

d. Age, Race, Sex, and Educational Characteristics

Age, race, sex, and education are important in assessing the balance of a program for vocational rehabilitation of the blind. The statistical probability of blindness varies with age and race, and to a lesser degree with sex. Placement potential varies with education. Imbalance indicates the possibility of improper screening of referrals.

The BSB caseload shows undue emphasis on young, male rehabilitants with a higher level of education than the U.S. average for blind rehabilitants. There is no indication of racial prejudice in screening.

Incidence of legal blindness is not uniform throughout all age groups. The Model Reporting Areas for Blindness Statistics (MRA) estimates a range from 54 blind per 100,000 persons under 20 to 1,098 blind per 100,000 persons 65 and over in FY 1965, with almost half the legally blind 62 years of age and older. Table 29 shows the BSB's age distribution pattern (prepared under the MRA program*) with estimates prepared by the National Society for the Prevention of Blindness.

The age distribution of BSB rehabilitants does not correlate with occurrence in the population, as Table 29 shows. Although the decline in the 45-64 age category was reversed in FY 1967, BSB rehabilitations of persons under 34 have continued to increase throughout the past four years.

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* These MRA rates may provide too low an estimate of incidence of legal blindness in Ohio and are being reviewed by the National Institute of Neurological Diseases and Blindness, which sponsors the program. Only four of the 14 states reporting are estimated to have a higher incidence of blindness than Ohio. Ohio, however, appears to conform closely with the MRA profile for general age distribution, with approximately 35 percent of its population in the age 40 and over bracket. In FY 1965 the State had 3.6 million residents aged 40 and over; 9.2 percent of the total population was age 65 and over.

TABLE 30 **
AGE, SEX, AND EDUCATION
BSB CLOSED CASES
FY 1966-FY 1967

Fiscal Year and Status	Average Age	Male/ Female Ratio	Highest Grade Completed
FY 1966			
U.S. Rehabilitated Cases (Status 26)	44	57/43	8
BSB Rehabilitated Cases (Status 26)	38	60/40	11
FY 1967			
BSB			
Rehabilitated Cases (Status 26)	38	59/41	9
Not Rehabilitated			
Closed After Plan Initiated* (Status 28)	38	59/41	10
Closed Before Plan Initiated* (Status 30)	42	59/41	10
Closed After Referral* (Status 08)	51	49/51	NA
TOTAL FY 1967	47	53/47	NA

* Clients pass through two screening processes before acceptance as active cases. Referrals are first roughly screened for eligibility; as applicants they receive more detailed investigation and appraisal. Drop-outs or rejects at both these stages are classified in Status 08. After the client achieves active case status, his VR counselor must prepare a rehabilitation plan for approval by his supervisors. Clients who drop out of the program before the plan is put into effect are classified in Status 30; those who drop out after plan initiation are classified in Status 28.

** V-3, Assessment of Agency Performance, p. V-8.

Furthermore, caseload statistics indicate that the BSB is more selective in screening referrals than the average U.S. agency for rehabilitation of the legally blind. Table 30 shows that the average age of BSB rehabilitants was six years lower than the average age of U.S. rehabilitants in FY 1966. The differences between the average ages of rehabilitants and nonrehabilitants give a clear pattern of discrimination because of age.

An average rehabilitant age of 62 is not to be expected in an agency with limited funds because of the difficulty in placing rehabilitants over 65 and their higher mortality rates. However, as noted in the BVR section, highest labor force participation rates are in the 25-54 age bracket for men and in the 45-54 bracket for women. A higher average age, at least approximately the average age of total closed cases, would appear warranted.

Statistically, race is a major determinant of probability of blindness. MRA statistics indicate that the incidence of legal blindness among Non-Whites (25.4 per 100,000 Non-Whites) is about 94 percent higher than among Whites (13.1 per 100,000 Whites). Ohio's population was about 8.2 percent Non-White, as opposed to the national 11.4 percent average. The racial distirbution of Ohio's legally blind population would, therefore, be 14.8 percent Non-White and 85.2 percent White.

In FY 1967, 14.4 percent (40) of BSB rehabilitants (278) were Non-White. The BSB certainly has been fair in its screening on the basis of race alone, although the proportion of Non-Whites should be increased as Ohio's Non-White population increases. (Core-city location of Non-White groups should simplify casefinding; on the basis of statistics, 200 Non-Whites could be rehabilitated annually.) Further investigation of the sex breakdown of Non-White participants might be warranted since the proportion of males is higher among Non-White blind than among Whites.

The BSB rehabilitates a higher proportion of males than are found in the general blind population and among its own referrals. As Table 30 shows, the proportion of males among BSB rehabilitants is significantly higher than among the BSB's Status 08 closures and total case closures and slightly higher than the proportion among total U.S.

TABLE 31 *
EARNINGS OF BSB REHABILITANTS (STATUS 26)
BEFORE AND AFTER SERVICE
FY 1963-FY 1967

Earnings per Week	Fiscal Year				
	1963	1964	1965	1966	1967
Before Service					
No Earnings	84.6%	89.1%	86.8%	86.3%	89.2%
Under $40	9.5	7.8	8.3	5.0	3.2
$40 and over	5.9	3.1	4.9	8.7	7.6
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
After Service					
No Earnings	19.4%	14.5%	1.2%	2.3%	25.9%
Under $40	44.4	44.6	47.4	46.0	20.1
$40 and over	36.2	40.9	51.4	51.7	54.0
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL NUMBER OF CASES	221	193	243	263	278

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* V-4, Assessment of Agency Performance, p. V-10.

blind rehabilitants (as it has been for the past three years).

Table 30 also shows that the educational level of BSB rehabilitants dropped sharply from FY 1966 to FY 1967 and is approaching the U.S. average. However, further analysis of the BSB figure indicates a steady growth since FY 1964 in the percentage of rehabilitants with a high school education, whose effect on the BSB average has been masked for the past two years by a decline in rehabilitants with more than a high school education.

e. Family, Income, and Placement Characteristics

The family (dependents), income, and placement characteristics of rehabilitants indicate return on investment to the community for its funding of their rehabilitation.

In FY 1966 fewer BSB rehabilitated clients (41 percent) had dependents than the U.S. average (45 percent), but the three-year trend has been toward closing this gap.

Table 31 compares earnings before and after service of cases closed rehabilitated during the period FY 1963-1967. The proportion of rehabilitants with earnings of $40 and more has shown a healthy increase (20.8 percent) over the past five years. However, the sudden jump of 23.6 percent in the proportion of rehabilitants without income after rehabilitation in FY 1967 is highly unfavorable. The breakdown appears to be in placement of marginal workers, capable of earning less than $40 per week, in sheltered industries, such as those sponsored by the BSB itself.

Table 32 presents some indicators of rehabilitation "quality" as denoted by placement of rehabilitants. The very low percentage of homemakers among the BSB cases in FY 1966 in comparison with the U.S. average reflects the BSB's adherence to a more rigid definition of rehabilita- than that now advocated by the RSA. Of perhaps greater significance is the high proportion of "previously rehabilitated" rehabilitants. This percentage increased to 24.0 percent in FY 1967. In combination with the jump

TABLE 32 *

INDICATORS OF REHABILITATION QUALITY OCCUPATIONS OF BLIND AT CLOSURE AND PERCENT PREVIOUSLY REHABILITATED CASES CLOSED REHABILITATED (Status 26)

FY 1966

Location	Professional	Homemakers	Previously Rehabilitated
United States	4.5%	26.8%	18.6%
RSA Region V	4.8	11.4	24.7
Ohio BSB	3.8	13.7	20.5

TABLE 33 **

REASONS FOR NONREHABILITATION OF CASES CLOSED (STATUSES 08, 28, AND 30)

FY 1967

Reason	Percent
Unable to Contact or Locate,	14.3
Moved, or Died	17.4
Handicap Too Severe	42.3
Refused Service	9.4
No Vocational Handicap	4.1
Client Institutionalized	0.2
Unfavorable Medical Prognosis	0.7
Transferred to Another Agency	0.7
Failure to Cooperate	0.9
Other	10.0
TOTAL	100.0

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* V-5, Assessment of Agency Performance, p. V-11.

** V-6, op. cit., p. V-12.

in rehabilitants with no earnings after closure, the rise presents a warning that quality of service to the more severely disabled may be declining.

f. Reasons for Nonrehabilitation

Another way to examine an agency's effectiveness is to review the reasons given for closure of nonrehabilitated cases. A summary of the reasons given for nonrehabilitated closures (Statuses 08, 28, and 30) in FY 1967 is given in Table 33 . Of total closures, 42.3 percent refused service and 14.3 percent were impossible to locate, moved, or died. Both reasons are related to service delays, which constitute denial of service because they increase the chances of "losing" the client or destroying motivation to participate. Studies have shown that the longer a client spends in referral status the less his likelihood of being rehabilitated. As discussed in greater detail under caseload processing, some BSB clients have to wait an undue length of time: 22 percent remained in referral status 9 months or more.

Comparison of the BSB's Status 08 closures with those of 36 other state agencies for the blind indicates that the BSB's screening process tends to select more easily rehabilitated clients than does the average U.S. agency's:

	Other U.S. Agencies	BSB
Handicap Too Severe	7%	19%
Lack of Disabling Condition	28	10
Lack of Vocational Handicap	8	5

The BSB screens out 12 percent more referrals than do other agencies as too severely handicapped and has a more permissive screen for the marginally handicapped: other agencies screen out 21 percent more referrals than does the BSB for lack of disabling condition and/or vocational handicap.

g. Caseload Processing

One of the most important aspects of caseload management is caseload processing. Counselors' time must be allocated not only for service of active cases, but also for contacts with potential clients. The flow of cases through the BSB is like the flow of material through a manufacturing plant. Referrals can be considered raw materials; cases being served, in-process inventory; cases closed not rehabilitated, scrap loss; and cases closed rehabilitated, finished product. Effective caseload management produces a maximum output of rehabilitants with a low scrap rate, insures minimal delay and an even work flow from one stage to the next, and forestalls build-ups in inventory. Figure 29 presents a schematic diagram of BSB caseload flow in FY 1967. (Table 34 gives the status legend for Figure 29.)

TABLE 34 *

REVISED RSA STATUSES LEGEND FOR FIGURE 29
(SCHEMATIC DIAGRAM OF CASELOAD FLOW--OHIO BSB)

Status	Title
00	Referral
02	Applicant
04	Six-Month Extended Evaluation
06	Eighteen-Month Extended Evaluation
08	Closed After Referral--from Status 00, 02, 04, or 06
10	Plan Development
14	Counseling and Guidance Only
16	Physical Restoration
18	Training
20	Ready for Employment
26	Closed Rehabilitated
28	Closed Not Rehabilitated After Rehabilitation Plan Initiated
30	Closed Not Rehabilitated Before Rehabilitation Plan Initiated

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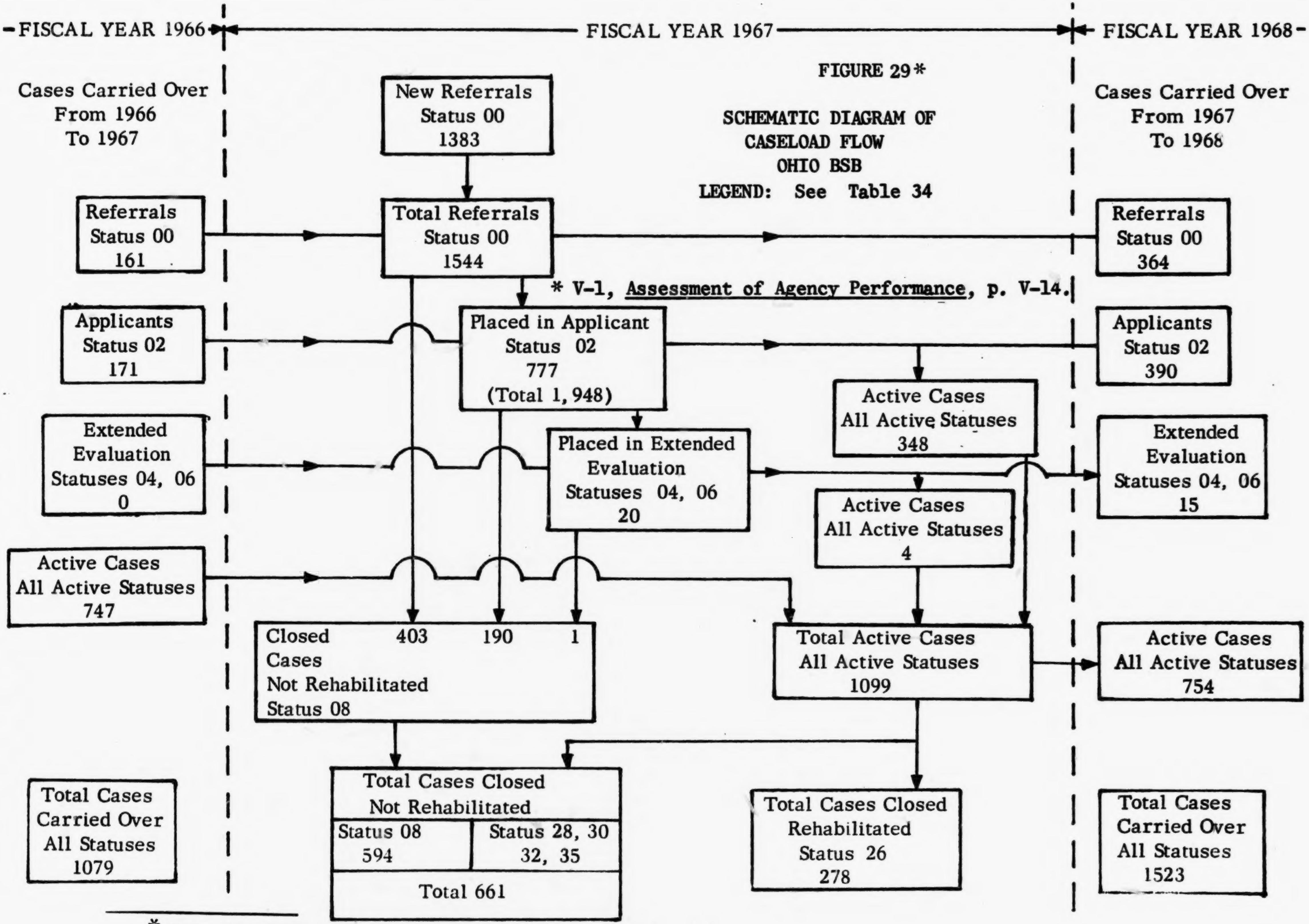
* V-7, Assessment of Agency Performance, p. V-15.

FIGURE 29*

SCHEMATIC DIAGRAM OF
CASELOAD FLOW
OHIO BSB

LEGEND: See Table 34


FISCAL YEAR 1966
FISCAL YEAR 1967
FISCAL YEAR 1968
Cases Carried Over From 1966 To 1967
Referrals Status 00 161
Applicants Status 02 171
Extended Evaluation Statuses 04, 06 0
Active Cases All Active Statuses 747
Total Cases Carried Over All Statuses 1079
New Referrals Status 00 1383
Total Referrals Status 00 1544
Placed in Applicant Status 02 777 (Total 1,948)
Placed in Extended Evaluation Statuses 04, 06 20
Closed Cases Not Rehabilitated Status 08
403
190
1
Total Cases Closed Not Rehabilitated
Status 08 594
Status 28, 30 32, 35
Total 661
Active Cases All Active Statuses 348
Active Cases All Active Statuses 4
Total Active Cases All Active Statuses 1099
Total Cases Closed Rehabilitated Status 26 278
Cases Carried Over From 1967 To 1968
Referrals Status 00 364
Applicants Status 02 390
Extended Evaluation Statuses 04, 06 15
Active Cases All Active Statuses 754
Total Cases Carried Over All Statuses 1523

* V-1, Assessment of Agency Performance, p. V-14.

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* V-1, Assessment of Agency Performance, p. V-14.

TABLE 35 *
BSB CASELOAD DATA
FY 1963-FY 1967, with Projections to FY 1969

Fiscal Year	Referrals Processed	Cases Accepted	Caseload Served	Cases Closed Rehabilitated (Status 26)	Cases Closed Not Rehabilitated (Status 08)	Percent of 08's to	
						Referrals Processed	Total Closures
1963	681	427	1,217	221	254	37.3	39.2
1964	505	336	1,159	193	169	33.5	32.6
1965	495	330	1,140	243	165	33.3	29.1
1966	658	357	1,095	263	301	45.7	44.6
1967	1,180	777	948	278	594	50.4	63.3
1968 (Est.)	NA	500	1,254	325	NA	57.0	NA
1969 (Est.)	NA	550	1,399	375	NA	55.0	NA

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* V-8, Assessment of Agency Performance, p. V-16.

A definite build-up in case inventories occurred during FY 1967. Total inventory increased by 41.2 percent, but active case inventory increased by only 0.9 percent. Referral inventory increased by 126.1 percent; and applicant inventory, by 128.1 percent.

The rehabilitation rate was low in proportion to the "scrap" rate in FY 1967. Of the total of 2,462 potential and active clients with which the BSB had contact in FY 1967, 11.3 percent were closed rehabilitated (Status 26), and 26.8 percent were closed not rehabilitated (Statuses 08, 28, and 30).

Table 35 shows the relationships of Status 08 nonrehabilitated closures to referrals processed and total closures for the period FY 1963-1967. The Ohio BSB has shown a marked rise in the relationship of Status 08 closures to processed referrals from 33.5 percent in 1964 to 50.4 percent in FY 1967, with estimates of 57 percent and 55 percent respectively for FY 1968 and FY 1969.

Equally serious was evidence of delay in service. Of the total of 2,462 potential and active clients in FY 1967, 61.9 percent were carried forward for further service in FY 1968 -- 30.6 percent of the total as active cases and 30.3 without having received any substantial service. Total referrals at year-end represented approximately 3.2 months of FY 1967 referral intake; and total applicants, an additional 3.4 months of FY 1967 referral intake.

Table 36 shows average time in process for cases closed in FY 1967. Total time in process for rehabilitants increased from 24 months in FY 1966 to 30.5 months in FY 1967. In FY 1967 rehabilitants waited 8.4 months for completion of rehabilitation plans: in other words, they waited 15 months to receive 15.5 months of case services.

Over the past five years, there has been a slow, but persistent increase in the number of clients who spend 13 months or more in referral status. Of those closed in Status 08, 22 percent spent 9 months or more in referral status. Even the average six-month period prior to rejection of Status 08 cases seems excessive. How long should it take to determine lack of a disabling condition or vocational handicap in a program restricted to serving the legally blind? If rejection rates were decreasing and

TABLE 36 *
AVERAGE TIME IN PROCESS
BSB CASES CLOSED FY 1967

	Months			
	Cases Closed Rehabilitated	Cases Closed Not Rehabilitated		
	Status 26	After Plan Status 28	Before Plan Status 30	Referral After Status 08
Average Time in Referral and Applicant Statuses	6.5	5	8	6
Average Time from Acceptance to closure	24	33	23	-
TOTAL TIME	30.5	38	31	6

delay in acceptance were the result of a pile-up in cases eventually to be accepted, there would be some justification. But Table 37 shows the contrary to be true.

h. Counselor Performance

The BSB's counselor-population ratio (0.234 per 100,000 residents) is high in proportion to the ratio for RSA Region V (0.176 per 100,000) and the U.S. average (0.161 per 100,000). However, counselor allocation to BSB district offices is not proportionate. In FY 1967 Cleveland had a counselor-population ratio of 0.17 per 100,000: Cincinnati, 0.16 per 100,000; Canton, 0.18 per 100,000; Columbus, 0.33 per 100,000; and Toledo, 0.25 per 100,000. The Columbus office produced 68 rehabilitations at a rehabilitation-population rate of 4.44 per 100,000, while Cincinnati had a rate of only 1.71 per 100,000, and Canton, 2.81 per 100,000. If the counselor-population ratios were equalized at the Columbus rate, Cincinnati would, for example, have produced at a 3.80 rate.

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* V-9, Assessment of Agency Performance. p. V-17.

Per counselor closure rates were generally low. In FY 1961 the U.S. average for rehabilitations per counselor was 15, as opposed to the BSB average of 10; by 1966 BSB rehabilitations had increased to 10.5 per counselor, but the U.S. average had increased to 18.3 in the same period. Even the BSB's projected rates for FY 1968 and FY 1969 fail to meet the U.S. average for FY 1961. Table 37 compares the slow growth in rehabilitations with the rapid increase (88.8 percent) in rejections per counselor since FY 1965.

TABLE 37 *
BSB COUNSELOR PERFORMANCE
CASE CLOSURES
FY 1963-FY 1967, with Projections to FY 1969

Fiscal Year	Counselor Man-Years	Number of Closures per Counselor: Closed Rehabilitated (Status 26)	Number of Closures per Counselor: Closed Not Rehabilitated (Status 08)
1963	21.6	10.2	11.7
1964	16.2	11.9	10.4
1965	17.6	13.8	9.3
1966	25.0	10.5	12.0
1967	23.5	11.8	25.2
1968 (Est.)	NA	12.0	NA
1969 (Est.)	NA	12.5	NA

The RSA recommended an average rate of 25 closures per counselor in a recent review: only one BSB counselor has achieved this rate although its staff has 12 experienced counselors at miximum grade (IV). In FY 1967 the six counselors with the highest production — 16 to 25 cases in Status 26 — closed 45 percent of BSB rehabilitations. These counselors were assigned as follows: Cleveland (2), Cincinnati (2), Canton (1), and Columbus (1). Toledo counselors could produce only a

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* V-10, Assessment of Agency Performance, p. V-19.

TABLE 38 *
SOURCES OF REFERRAL FOR BSB CASES CLOSED REHABILITATED (STATUS 26)
FY 1963–FY 1967

Source	Fiscal Year				
	1963	1964	1965	1966	1967
Educational Institutions	10.4%	6.2%	6.6%	9.9%	10.4%
Hospitals	0.9	-	0.8	0.4	0.7
Other Health Agencies	15.4	20.7	14.4	13.7	12.6
Physicians	4.5	2.6	4.1	3.4	6.1
Social Security Administration and Workmen's Compensation	3.6	5.2	9.1	5.3	8.6
Welfare	25.4	21.2	19.8	27.0	22.7
State Employment Service	1.8	-	0.8	0.7	1.1
Family and Friends	9.5	8.8	12.3	7.6	9.0
Self	21.7	27.5	23.5	24.0	20.1
Other	6.8	7.8	8.6	8.0	8.3
Not Reported	-	-	-	-	0.4
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
NUMBER OF REHABILITATIONS	221	193	243	263	278

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* V-11, Assessment of Agency Performance, p. V-20.

range of 8 to 11 closures in Status 26.

i. Referral Sources

In FY 1967 the BSB's major sources of referral were Public Welfare, other health agencies, and Social Security, which accounted for 66 percent of total referrals. However, these sources accounted for only 46 percent of closed rehabilitated cases. (See Table 38). On the other hand, educational institutions, physicians, and self-referrals accounted for only 19 percent of total referrals, but produced 36.6 percent of rehabilitations.

The major trends among rehabilitated cases are a five-year decline in self-referrals and referrals from other health agencies and a FY 1966-1967 decline in Welfare referrals. The two long-term declines indicate the general decrease in public awareness of BSB programs.

Of cases closed not rehabilitated (Status 08) in FY 1967, over 78 percent were referred by Welfare (41.5 percent), other health agencies, and Social Security. Educational institutions, physicians, and self-referrals, by contrast, accounted for only 9.6 percent of Status 08 closures.

In FY 1967 the BVR referred only 31 clients to the BSB, and the BSB referred a similarly small number to the BVR. Considering the number of clients who must be on the borderline between visual handicap and legal blindness, these referrals are suprisingly small.

Expenditure Patterns

a. Introduction

The following subsection presents the results of a series of analyses designed to assess the pattern of expenditures for the BSB's vocational rehabilitation program. First, we analyze the BSB's total Section 2 budget and expenditures for the case services.

Then, we present a brief assessment of costs of rehabilitated and nonrehabilitated cases and the case services budget per counselor.

b. Section 2 Budget

The Ohio BSB's per capita expenditures for rehabilitation of the legally blind in FY 1966 were high in relation to averages for the region and the country:

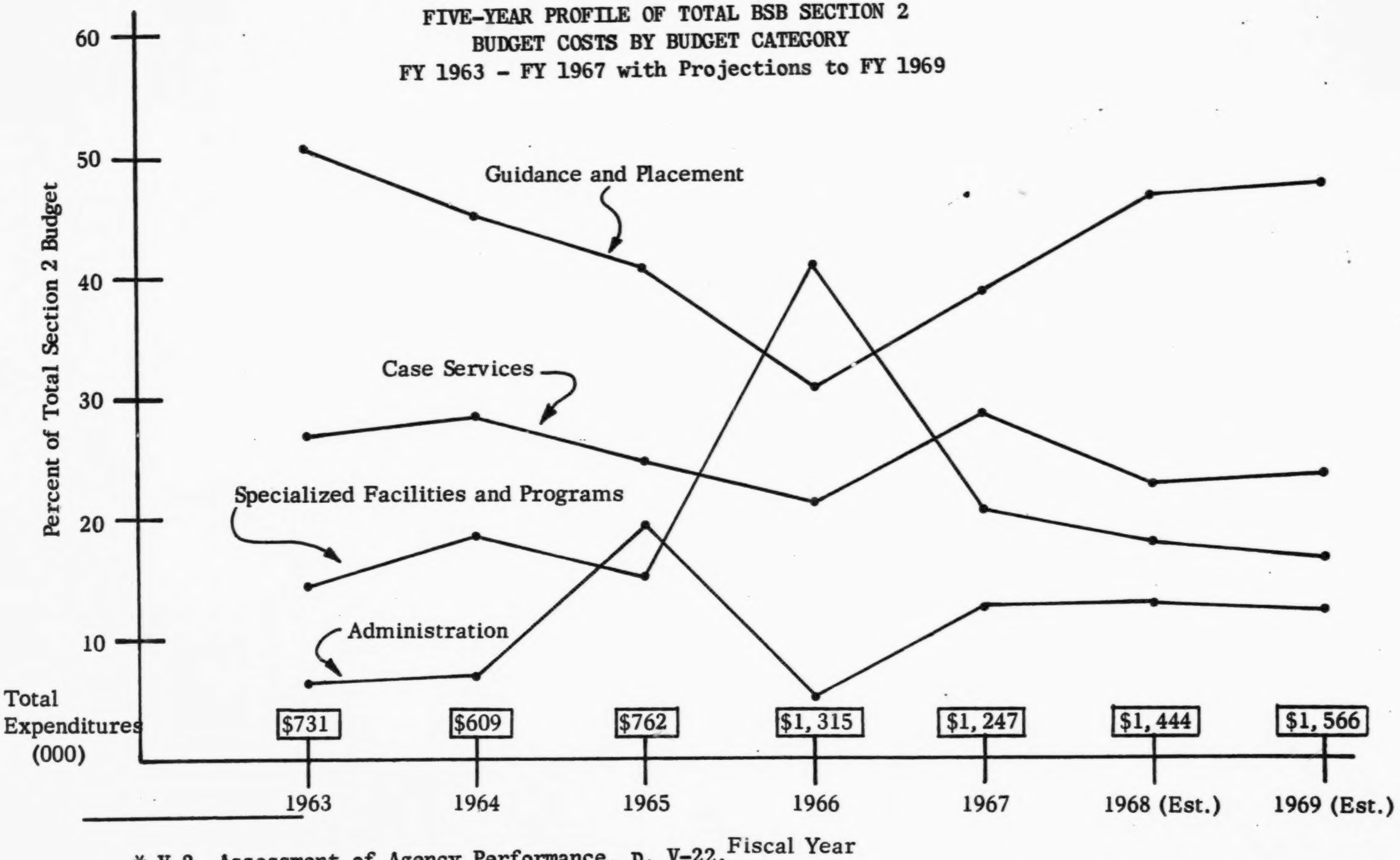
Ohio	$0.12
RSA Region V	0.07
U.S.	0.09

Figure 30 shows the allocations of the BSB's Section 2 budget for the period FY 1963 to FY 1967, with projections to FY 1969. The Section 2 budget covers Administration, Guidance and Placement, Specialized Facilities and Programs, and Cases Services. Administration includes costs associated with State Office supervision; Guidance and Placement, district office counseling services; Specialized Facilities and Programs, improvements to third-party rehabilitation facilities; and Case Services, services purchased from outside sources for the rehabilitation of clients.

The proportion of the Section 2 budget spent by the BSB on case services is low. In FY 1961 the BSB spent only 25 percent of this budget for case services as compared with the U.S. average of 43 percent. In FY 1966 the BSB's allocation was 21.9 percent as opposed to the U.S. average of 44.7 percent. In FY 1967 the BSB's case services allocation only represented 28.4 percent of its Section 2 budget.

Estimated proportions of case services to total budget for FY 1968 (23.5 percent) and FY 1969 (23.9 percent) reflect only the budget submitted by the BSB. The legislature — without solicitation by the DPW or the BSB — voluntarily raised the case services appropriations for FY 1968 and FY 1969 by $90,000 per year. The adjusted percentages of case services to total budget will be 28.0 percent (FY 1968) and 28.1

FIGURE 30 *
FIVE-YEAR PROFILE OF TOTAL BSB SECTION 2
BUDGET COSTS BY BUDGET CATEGORY
FY 1963 - FY 1967 with Projections to FY 1969



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* V-2, Assessment of Agency Performance, p. V-22.

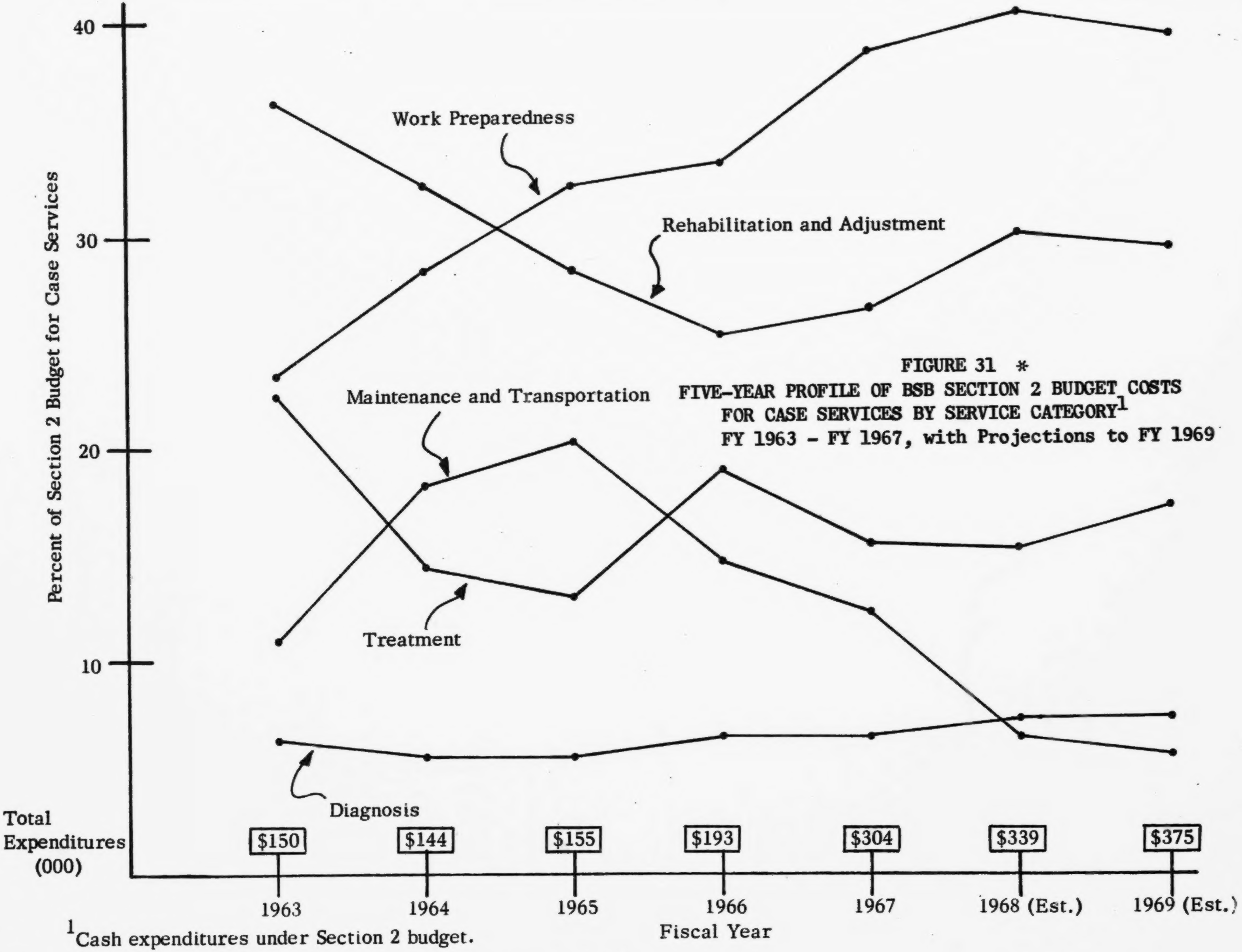

FIGURE 31 *
FIVE-YEAR PROFILE OF BSB SECTION 2 BUDGET COSTS FOR CASE SERVICES BY SERVICE CATEGORY[1]
FY 1963 - FY 1967, with Projections to FY 1969

[1] Cash expenditures under Section 2 budget.

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* V-3, Assessment of Agency Performance, p. V-24.

percent (FY 1969), substantial improvements over the BSB's FY 1967 level, but still much lower than the U.S. average in FY 1961.

Despite proportional changes guidance and placement and case services showed a steady dollar increase from FY 1964 to FY 1967.

c. Costs of Case Services

Figure 31 presents a breakdown of case services expenditures for FY 1963 to FY 1967 and projections to FY 1969. All categories except maintenance and transportation (which showed an irregular pattern) increased steadily in dollar volume from FY 1964 to FY 1967. Work preparedness, which includes college tuition, increased by 234 percent from FY 1963 to FY 1967.

d. Costs of Rehabilitated and Nonrehabilitated Cases

The average case services cost, accrued from referral through closure, for cases rehabilitated in FY 1967 was $772.63.

For national comparison purposes, a rough measure of annual costs per rehabilitation is obtained by dividing total annual expenditures under Section 2 (less investment in rehabilitation facilities) by number of rehabilitations. The BSB's cost per rehabilitation rose sharply in FY 1967 to exceed the FY 1966 average by 21.6 percent:

FY	BSB	U.S.
1961	$2,823	$2,137
1966	2,912	2,927
1967	3,560	NA

TABLE 39 *
BSB REHABILITATIONS AND CASE SERVICES BUDGETS PER COUNSELOR
FY 1963-FY 1967, with Projections to FY 1969

Fiscal Year	Rehabilitations per Counselor	Case Services Budget per Counselor
1963	10.2	$ 9,245
1964	11.9	10,643
1965	13.8	9,993
1966	10.5	11,497
1967	11.8	15,084
1968 (Est.)	12.0	12,555
1969 (Est.)	12.5	12,500

---

* V-12, Assessment of Agency Performance, p. V-26.

The average case services cost, accrued from referral through closure, for cases closed not rehabilitated in FY 1967 were:

Status 08	$ 2.90
Status 28	485.04
Status 30	46.03

The average cost for Status 08 appears understated. Actually 503 cases bore no costs; 81 received services averaging $210 apiece.

e. Case Services Budget per Counselor

Table 39 compares the BSB's average rehabilitation rate per counselor and case services budget per counselor from FY 1963 to FY 1969. In FY 1961 the BSB's case services budget per counselor was $7,466 as compared to the U.S. average of $13,257. By FY 1966 the BSB's case services budget per counselor had increased 54.0 percent, but over the same period, the U.S. average budget per counselor had increased 80.9 percent to $23,984. In FY 1967 the BSB finally exceeded the U.S. average budget per counselor for FY 1961. Although in FY 1967 the BSB finally exceeded the U.S. average budget per counselor for FY 1961, it was still 37 percent below the average U.S. budget for FY 1966.

The estimated budgets shows in Table 39 for FY 1968 and 1969 do not include the $90,000 per annum in additional case services funds voted by the legislature, but are shown to indicate the BSB's lack of statistical inputs in budgeting. The estimated budgets for FY 1968 and FY 1969 are 5.6 and 5.2 percent below the U.S. FY 1961 budget. With the increases, the case services budgets per counselor are $15,900 (FY 1968) and $15,500 (FY 1969), certainly a substantial improvement. However, even the revised per counselor budgets are 33.7 percent (FY 1968) and 35.4 percent (FY 1969) below the U.S. average for FY 1966.

CHAPTER V

STUDY PROCEDURE

ORGANIZATIONAL STRUCTURE

A. Governor's Council on Vocational Rehabilitation

1. Governor's Council

In November, 1966, the Governor of Ohio appointed a small, but widely representative, Governor's Council on Vocational Rehabilitation to assume responsibility for the entire survey. It is representative of the following categories: Ohio Legislature, business and industry, labor, medicine, education, religion, and the disabled. Directors of the Bureau of Vocational Rehabilitation and the Bureau of Services for the Blind were ex-officio members of this Council.

2. Executive Committee

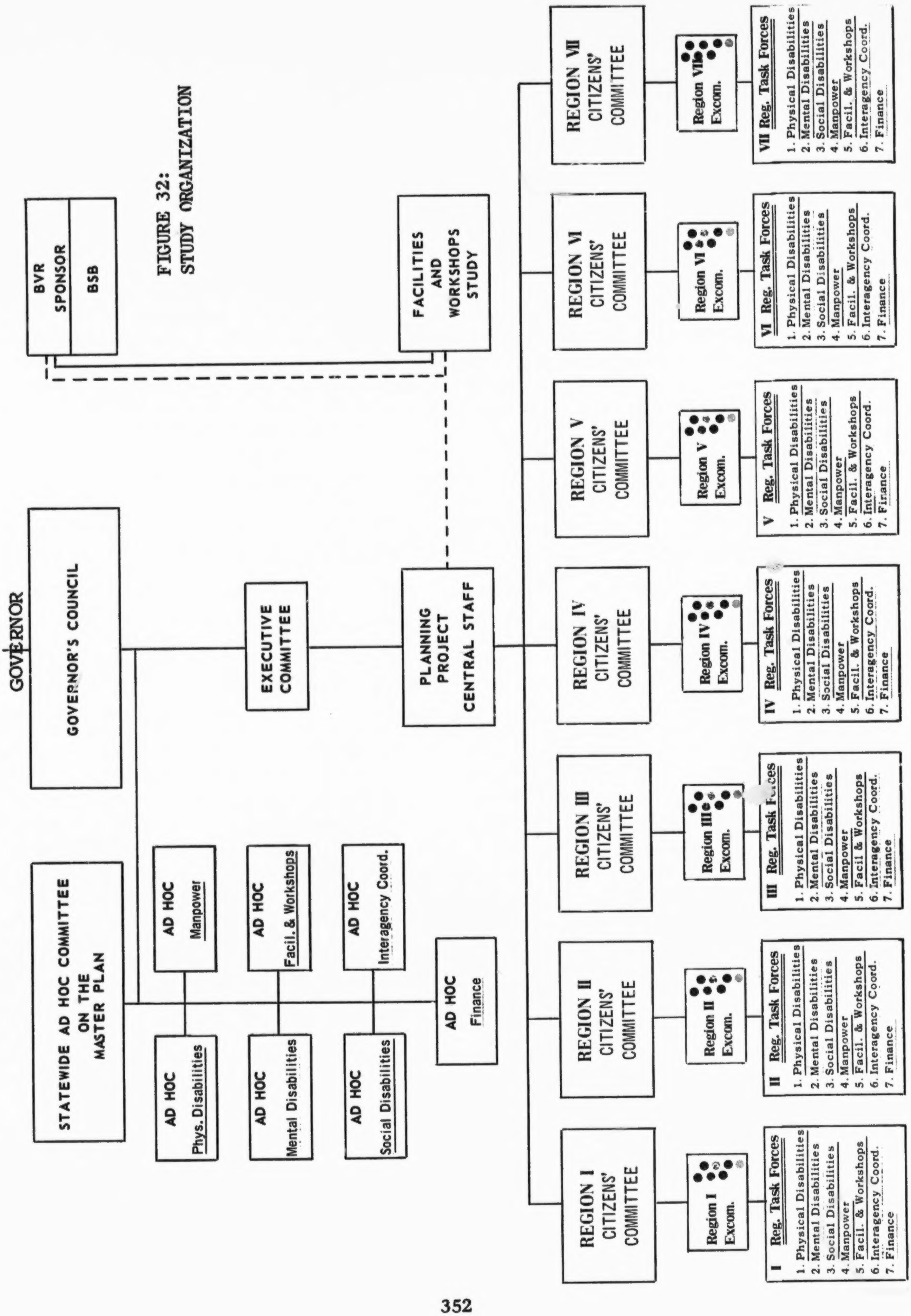
The Governor's Council designated an executive committee from its membership to act between the Council's quarterly-scheduled meetings.

3. Governor's Council Ad Hoc Committees

Regional Task Force Chairmen for each respective Task Force comprised the Ad Hoc Committees on Physical, Mental, and Social Disabilities, Manpower, Interagency Coordination, Facilities and Workshops, and Finance.

The Statewide Ad Hoc Committee on the Master Plan included membership representative of leaders throughout the State in business, industry, government and legislation, medicine, human services, and rehabilitation. These Ad Hoc Advisory Committees performed a particularly critical function during the final six months of the Study when six Statewide Ad Hoc Committees - one on each study area of the sixty-three Regional Task Forces - met to review the Regional Task Force recommendations and developed criteria for setting their recommendations in some order of priority. The six Statewide Ad Hoc Committees set forth certain key recommendations of high priority which if implemented the committees felt could then effect the carrying out of the many, more detailed Regional Recommendations related to the major categories of the Study and related to the unique needs of a

FIGURE 32: STUDY ORGANIZATION


GOVERNOR
GOVERNOR'S COUNCIL
BVR SPONSOR
BSB
EXECUTIVE COMMITTEE
PLANNING PROJECT CENTRAL STAFF
FACILITIES AND WORKSHOPS STUDY
STATEWIDE AD HOC COMMITTEE ON THE MASTER PLAN
AD HOC Phys. Disabilities
AD HOC Manpower
AD HOC Mental Disabilities
AD HOC Facil. & Workshops
AD HOC Social Disabilities
AD HOC Interagency Coord.
AD HOC Finance
REGION I CITIZENS' COMMITTEE
Region I Excom.
I Reg. Task Forces
1. Physical Disabilities
2. Mental Disabilities
3. Social Disabilities
4. Manpower
5. Facil. & Workshops
6. Interagency Coord.
7. Finance
REGION II CITIZENS' COMMITTEE
Region II Excom.
II Reg. Task Forces
1. Physical Disabilities
2. Mental Disabilities
3. Social Disabilities
4. Manpower
5. Facil. & Workshops
6. Interagency Coord.
7. Finance
REGION III CITIZENS' COMMITTEE
Region III Excom.
III Reg. Task Forces
1. Physical Disabilities
2. Mental Disabilities
3. Social Disabilities
4. Manpower
5. Facil & Workshops
6. Interagency Coord.
7. Finance
REGION IV CITIZENS' COMMITTEE
Region IV Excom.
IV Reg. Task Forces
1. Physical Disabilities
2. Mental Disabilities
3. Social Disabilities
4. Manpower
5. Facil. & Workshops
6. Interagency Coord.
7. Finance
REGION V CITIZENS' COMMITTEE
Region V Excom.
V Reg. Task Forces
1. Physical Disabilities
2. Mental Disabilities
3. Social Disabilities
4. Manpower
5. Facil. & Workshops
6. Interagency Coord.
7. Finance
REGION VI CITIZENS' COMMITTEE
Region VI Excom.
VI Reg. Task Forces
1. Physical Disabilities
2. Mental Disabilities
3. Social Disabilities
4. Manpower
5. Facil. & Workshops
6. Interagency Coord.
7. Finance
REGION VII CITIZENS' COMMITTEE
Region VII Excom.
VII Reg. Task Forces
1. Physical Disabilities
2. Mental Disabilities
3. Social Disabilities
4. Manpower
5. Facil. & Workshops
6. Interagency Coord.
7. Finance

given Region.

On June 18, 1968, the Statewide Ad Hoc Advisory Committee on the Master Plan met to consider the findings and recommendations of the six Statewide Ad Hoc Committees in order to finalize a master plan for implementation, to be presented to the Governor's Council on Vocational Rehabilitation. This Advisory Committee set forth those major statewide recommendations which, when implemented, would carry out the key recommendations of the earlier Ad Hoc Committees -- and thus, in turn as stated above, the more specified and numerous Regional Task Force recommendations would be implemented. That Master Plan, and the recommendations necessary to effect it, were analyzed, refined and referred by unanimous consensus to the Governor's Council for its final consideration and action June 27, 1968. (Refer to Chapter II for Final Major Recommendations of the Governor's Council acted upon June 27, 1968.)

B. Staff Organization for Statewide Planning for Vocational Rehabilitation

1. Planning Staff Administration - Central Office

Robert L. Davis Project Director	Marilyn A. Quigley Executive Assistant
David H. Tait, Ed.D. Associate Project Director and Research Coordinator	George E. Reavell State Coordinator

2. Statewide Planning Regional Coordinators

Operating out of Regional Bureau of Vocational Rehabilitation offices Coordinators have been instrumental in assisting the Regional Citizens' Committee Chairmen and Task Force Chairmen and members to carry out their proposals. These Coordinators first functioned locally in procuring personnel for the Regional Committees and Task Forces. Subsequent activities included making arrangements for meetings, helping members and groups to define the job to be done, and suggesting ways in which to achieve Regional objectives. Considerable effort went into coordinating, data gathering, making local compilations, and

PLANNING REGIONS

AND POPULATION FIGURES

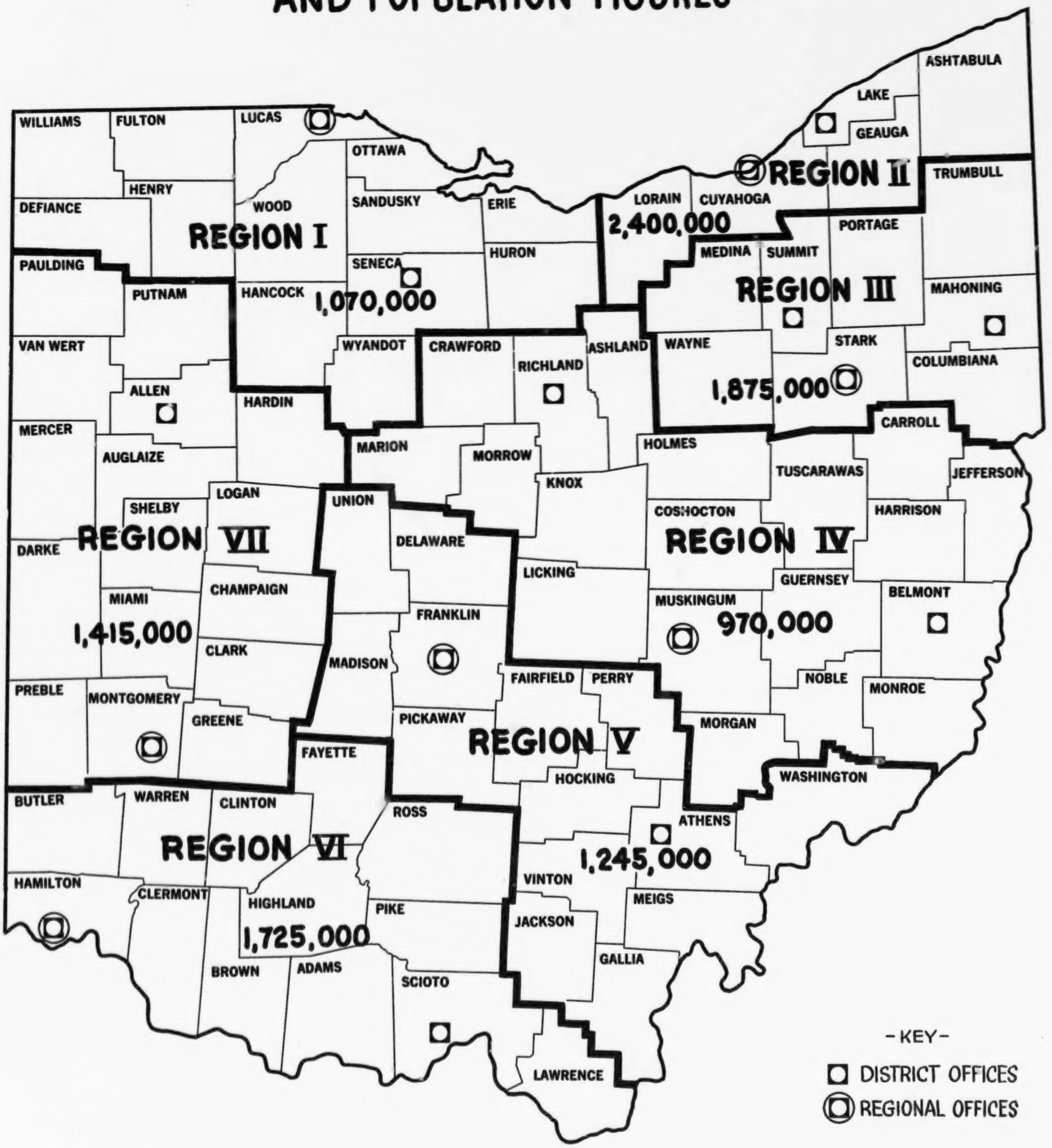

REGION I
1,070,000
REGION II
2,400,000
REGION III
1,875,000
REGION IV
970,000
REGION V
1,245,000
REGION VI
1,725,000
REGION VII
1,415,000
WILLIAMS
FULTON
LUCAS
OTTAWA
DEFIANCE
HENRY
WOOD
SANDUSKY
ERIE
HURON
PAULDING
PUTNAM
HANCOCK
SENECA
VAN WERT
ALLEN
HARDIN
WYANDOT
CRAWFORD
RICHLAND
ASHLAND
MERCER
AUGLAIZE
MARION
MORROW
KNOX
SHELBY
LOGAN
UNION
DELAWARE
DARKE
MIAMI
CHAMPAIGN
CLARK
MADISON
FRANKLIN
LICKING
PREBLE
MONTGOMERY
GREENE
FAYETTE
PICKAWAY
FAIRFIELD
PERRY
BUTLER
WARREN
CLINTON
ROSS
HOCKING
HAMILTON
CLERMONT
HIGHLAND
PIKE
VINTON
JACKSON
BROWN
ADAMS
SCIOTO
GALLIA
LAWRENCE
MEIGS
ATHENS
MORGAN
WASHINGTON
NOBLE
MONROE
MUSKINGUM
GUERNSEY
BELMONT
COSHOCTON
HARRISON
TUSCARAWAS
HOLMES
CARROLL
JEFFERSON
WAYNE
STARK
COLUMBIANA
MEDINA
SUMMIT
PORTAGE
MAHONING
LORAIN
CUYAHOGA
GEAUGA
LAKE
ASHTABULA
TRUMBULL
-KEY-
DISTRICT OFFICES
REGIONAL OFFICES

FIGURE 33

reporting as Executive Secretary to the Regional Citizens' Committee Chairmen.

C. Regional Organization

1. Regional Citizens' Committee

Each of the seven Regions had a Regional Citizens' Committee of approximately thirty-five members headed by a Regional Citizens' Committee Chairman. Regions II, III, and IV subdivided responsbilities to better adjust to local, geographical and demographic conditions thus incurring some unique variations from the organizational patterns followed in other regions.

This group, chosen as a cross-section from citizens in the Region, served in an advisory capacity to the Regional Citizens' Committee Chairman who was responsible for the over-all Task Force activity in his Region.

2. Regional Executive Committee

This advisory-study group in each Region consisted of the Chairmen of all of the Task Forces in that Region and functioned as a Regional interdisciplinary coordinating body for the study. It served to prevent overlapping of Task Force efforts, and to develop and integrate the Regional Master Plan.

3. Regional Task Forces

Typically, seven Regional Task Forces, each operating under a chairman, surveyed an assigned major category of the total study.

D. Relationship to State Rehabilitation Agencies

1. Statewide Planning Study Sponsorship

Designee - Bureau of Vocational Rehabilitation
(Department of Education)
Edward J. Moriarty, Director

Co-Sponsor - Bureau of Services for the Blind
(Department of Public Welfare)
Everett R. Steece, Chief

2. Coordination with Facilities and Workshops Study

Coordination with the concurrent Facilities and Workshops Study has permitted the use of data already gathered by the BVR Facilities and Workshops Study group conducted through the BVR Program Development Section. This has made available to Statewide Planning Task Forces studying Facilities and Workshops these data plus the personal interpretations of the Program Development staff members who were ex-officio members of these particular Regional Task Forces. This represented a substantial amount of information already compiled and available for study by the members of the Regional Task Forces.

PURPOSE AND DESIGN OF THE STUDY

Under the direction of the Governor's Council on Vocational Rehabilitation, the Bureau of Vocational Rehabilitation and Bureau of Services for the Blind jointly sponsored a two-year statewide comprehensive study of vocational rehabilitation needs and resources designed to develop a long-range plan to serve all disabled persons in Ohio who need and can profit from services by 1975, or earlier.

This project, which began in November of 1966, had as its objective the determining of the number, nature, and needs of the disabled people in Ohio, the evaluation of present services and facilities in relation to these needs, and the immediate and long-range actions required to provide for the needs of these people.

The study sought to assess the public, and private, resources available and/or required to meet present and future needs, including requirement for, and utilization of, rehabilitation facilities and workshops for the disabled; and to outline ways in which state, local government, and voluntary programs and services for the handicapped (including local and regional planning bodies), may be recruited, and utilized, to facilitate, and implement, a statewide vocational rehabilitation program.

INTERSTATE RESEARCH COMPONENTS

In a pooling of efforts and resources with Illinois, Indiana, Michigan, and Wisconsin, Ohio shared in the results of the following research projects.

A. RIS Abstracts

The development of an annotated, bibliographical, rehabilitation-oriented information retrieval system, jointly sponsored by the aforementioned states. Once this system became operative in each of the participating states, it was kept up to date as a central source of information consisting specifically of vocational rehabilitation related materials, and coded to be consistent with the disability categories of the Bureau of Vocational Rehabilitation. This ensured rapid availability by punched cards at first, and later by IBM cards, of all the pertinent literature in the rapidly growing field of Rehabilitation.*

B. Telephone Survey and Counselor Follow-Up

In order to establish bench mark statistical data on incidence and prevalence of disability in the states cooperating in VRA Region V, a pooling of efforts and resources in areas of mutual interest to statewide planning was effected. The Survey Research Laboratory of the University of Wisconsin at Madison, in cooperation with the University's Regional Rehabilitation Research Institute, developed a telephone survey for use in the states cooperating in this venture. This pooling of efforts resulted in a considerable economy in that only one instrument needed to be designed and tested, and the same personnel trained in its use were able to cover the entire sampling areas in each state by WATS telephone service. After the initial screening to locate households with disabled persons, personal follow-up interviews arranged in each state added additional information to the incidence/prevalence statistics already being processed. Much of the data analysis service was provided by the Rehabilitation Research Laboratory. These data were thus directly comparable to those obtained by other participating states.**

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* _Cf_. APPENDIX VII.

** Cf. APPENDIX III.

RESEARCH COMPONENTS: OHIO

A. Contracts

A study of the Ohio Bureau of Vocational Rehabilitation and the Ohio Bureau of Services for the Blind was conducted by Harbridge House, Inc., with the express purpose of measuring the present effectiveness of the agency and suggesting ways in which the demands of anticipated future needs may be met. Greenleigh Associates, Inc. conducted a study of state level interagency coordination in relation to vocational rehabilitation in the state. Findings of both studies form portions of this final report.

B. Cooperative Agreements

As previously mentioned, coordination with the Bureau's concurrent Facilities and Workshops Study permitted the use of data gathered by the BVR Facilities and Workshops Study group.

OVERVIEW OF THE TWO-YEAR STUDY ACTIVITY

A. Orientation Manual

The Comprehensive Statewide Planning Orientation Manual was prepared expressly for presentation to each new member involved in the Statewide Study. It included basic information needed for citizens to understand the overall operating principles, design and objectives. It explained the geographical divisions and contained other information essential to these members in discharging their responsibilities in the project.

B. Guidelines

For each of the seven Task Forces a suitable guideline was produced and distributed in January, 1967. These reviewed the derivation of authority, strategic function, limitations in size, assistance available, and a generalized suggested set of objectives for each Task Force.

C. Position Paper Reference Materials

In February, 1967, these materials, as they were procurred and developed, were sent to the Regions for use as a ready source of pertinent reference information. One block included general, overall, background material specifically selected to assist Regional Citizens' Committee Chairmen, Executive Committees, and Citizens' Committee members in the performance of their duties. Other blocks of suitable reference materials were sent to all Task Force Chairmen.

Over 100 documents were directed to citizens who had a need for this information. This resulted in more than 700 actively involved citizens, scattered all over the State of Ohio, who became increasingly well informed about the rehabilitation concept, movement, and operation. This was considered essential to the success of a grass-roots, citizen-conducted study.

D. Statistical Support Data and Material

Beginning in March, 1967 a series of statistical and graphic supportive data and information productions were made available to all Regional personnel. These covered a wide range of mathematical calculations, charts and graphs, maps and documents on which to begin assessing the rehabilitation potential of the Region.

Wherever possible, extrapolation and projection, as well as all other presentations, were reduced to the county level. These blocks of data were compiled into reference files set up county by county to give the best possible estimates of population, incidence and prevalence of disability, economic considerations, and rehabilitation activities. Over forty different sets of statistical support materials and calculations were developed and distributed. These packets proved very helpful to planners not only in Statewide Planning for Vocational Rehabilitation, but to other groups interested in knowing the present status and future potential of the counties for a variety of purposes. These county compilations are viewed as an on-going research planning adjunct originated and implemented in the course of Statewide Planning.

E. Administrative and Consultative Services

In addition to fulfilling the requirements for long-range as well as daily administrative services, the Central Office staff actively engaged in providing for the interagency flow of information into and out of the project, compiling and processing data resulting from Task Force activities, providing and arranging for consultative services where these were needed, and representing Statewide Planning at the Local, Regional, State, Federal Region V, and National levels.

F. Circulation of Minutes of Task Force and Executive Committee Meetings

From March to June of 1967, a critical period in which many Task Force Chairmen were organizing their groups and conducting their initial meetings, a total of 25 sets of minutes were circulated to assist in the development and conducting of these Task Force meetings. This had additional effects, such as: the infusion of new ideas into a Region; the fostering of a sharing of knowledge and plans developing in the Regions; and, through channels of mutual interest, acquainting Task Force chairmen and members with their counterparts in other sections of the state. When all Task Forces were operating effectively and independently making progress, this service, having fulfilled its need, was curtailed.

G. Data Processing

With the increased Task Force emphasis on informative and statistical data gathering in their respective Regions, the need for programming and data processing became a substantial part of the work load of the research support group of the Central Office. Data gathering devices to be used in local studies were reviewed for the purpose of facilitating the data processing and information retrieval when they were sent in to the Central Office. Time on a 7094 IBM computer system was arranged for, to supplement that of other systems with the purpose of processing most economically the different devices being used. The Greenleigh Schedule, and the Region III modification for in-depth study of several counties, will provide a substantial basis for further Regional and Statewide research.

H. Information Exchange With Other States

Reference files were set up to compile the materials sent in as a result of the reciprocal exchange of information pertinent to the planning projects in states involved in Statewide Planning. States and territories that have been exchanging ideas and materials with Ohio regularly include:

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Kentucky
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Jersey
New Mexico
New York
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Texas
Utah
Vermont
Washington
West Virginia
Wisconsin
Wyoming

District of Columbia
Virgin Islands
Guam

I. Seminar Series

The Seminar Series was instituted to bring together Task Force Chairmen throughout Ohio with authorities on the subjects under discussion and people who would be involved with implementing the recommendations of the Regions.

Task Force Seminars were held as follows:

Seminar on Social Disabilities - April 18, 1967;
Seminar on Manpower - April 20, 1967;
Seminar on Physical Disabilities - April 24, 1967;
Seminar on Interagency Coordination and Continued Planning - April 26, 1967;
Seminar on Mental Disabilities - Arpil 27, 1967;
Seminar on Facilities and Workshops - April 28, 1967.

J. Workshop Sessions

June 16, 1967, an all day series of workshops for Task Force Chairmen was held at the Neil House in Columbus. The purpose was to allow Chairmen of Task Forces on the same study area in all seven Regions to meet together and report on their respective progress, to compare plans, problems, activities, and to exchange ideas and materials.

At the same time, the Regional Citizens' Committee Chairmen, with their Regional Coordinators, met for the first time in joint session to discuss the Statewide Study as it was developing under their direction in the respective Regions.

The Workshop Sessions were preceded by, and followed by, a General Assembly. These sessions were landmarks in the progress of the Statewide Planning procedure and proved again the value of having active citizen participation in conducting a study of this type.

K. Procurement of New Data at the Regional Level

In order to more completely evaluate local conditions to a greater degree than is possible using extrapolated data, several groups decided to develop and use data gathering instruments designed specifically for local in-depth study. Some examples of this would include: Old Age Survivors Disability Insurance Inquiry; Ohio Vocational Rehabilitation - Statewide Planning Agency Schedule; Region III Modified Greenleigh Schedule; Survey of Rehabilitation Resources (Region II); State Workshops and Rehabilitation Facilities Plan Inventory; Manpower Questionnaire Region I; Region IV Inter-agency Coordination Task Force Interviews Report; Region V Physical Disabilities Task Force Evaluation Check Lists.

A brief on Regional instruments used would include:

1. The OASDI Study in Region III resulted in 580 usable returned questionnaires. These have been subjected to programming, data extraction, and initial review. Mahoning, Portage, Trumbull, and Wayne counties were included in this study.

2. Nine hundred Greeleigh Schedules were sent to the Regions requesting them, namely: Region III, IV, V, VI, and VII. From these regions, they were sent out to respondents; upon return

were programmed for processing. The resulting compilation was sent to Greenleigh Associates in New York for interpretation. These were routed to the appropriate Task Forces for their use in discharging their responsibilities concerned primarily with the Interagency aspects of the study.

3. The Survey of Rehabilitation Resources (Region II) questionnaire was distributed to public and private rehabilitation related agencies in Region II. The data tabulations were handled locally as the returns came in and were made available to the Task Force members in the area.

4. The Region III Modified Greenleigh Schedule was revised many times to better adapt it to the in-depth assessment of agency performance use in the Starks-Wayne county area. Details of findings obtained from this instrument are given in Chapter IV of the Region III final report.

5. The State Workshops and Rehabilitation Facilities Plan Inventory was used as a mail-out and was followed up by a personal interview. Later, an addendum to the Questionnaire was sent out to the Facilities and Workshops included in the initial survey and these additional data too were made available to the Facilities and Workshops Task Forces to assist them in their studies of these units.

6. Other Regional questionnaires were utilized to identify and evaluate gaps and to provide Task Force members with information not otherwise obtainable. (Refer to each Regional Report for further details).

L. Federal Region V

Ohio Statewide Planning's participation in Federal Region V Planning Conferences was an indispensable assist to the Ohio Statewide Study. These quarterly meetings provided a broad base for comparison of Study data and effected some substantial savings through cooperative study projects.

As a sample of these meetings - the eighth meeting of the Statewide Planners of Federal Region V: Illinois, Indiana, Michigan, Ohio, and Wisconsin (coordinated by Mr. Stanley Hedstrom, Assistant Commissioner, Rehabilitation Services Administration), was held in Cleveland, Ohio, October 5, 1967, following the National Rehabilitation Association Annual Meeting. The Washington Director of all statewide vocational rehabilitation planning, Mr. Ralph Susman, was present; Mr. Elmer Engstrom, Vice President, Harbridge House, acted as moderator in the group discussion series. Some of the topics discussed included: the implications of the reorganization of the Department of Health, Education, and Welfare for Comprehensive Statewide Planning; Implementing and Coordinating the Results of Comprehensive Statewide Planning; Progress Reports and Discussions; Telephone Survey and the Information Retrieval System Reports.

M. Study Reports

Prior to this Final Report, an Annual Report and an Eighteen-Month Report were published by the central office staff. The Annual Report covered the period July 1, 1966-June 30, 1967. The Eighteen-Month report, prepared December 10, 1967, covered the period July 1, 1967-December 30, 1967. Activities conducted from December 30, 1967 to June 30, 1968 included preparation and printing of the final reports from each region, and Statewide Ad Hoc Committee Meetings/Meeting of the Governor's Council in preparation of recommendations to be incorporated into this Final Report.

PUBLIC RELATIONS ASPECTS OF THE STUDY

A. Educational Involvement with Citizens Participating in the Study

One of the most difficult things to measure, and yet one of the most promising in terms of implementation and long range effects for rehabilitation, is the social impact of the educational efforts of the Statewide Planning Study.

Specifically, over 700 citizens had a need for orientation to the current thinking in rehabilitation, its significance, application, and potential for implementation. This varied from refresher, briefing type of exposures for professionals in the field, to educating people with no rehabilitation frame of reference at all. Each member had to learn enough to become a competent, productive member of a study group as rapidly as possible. To accomplish this, the 100 documents were made available and coded to those particular groups which would profit most by becoming familiar with them. Also, statistical supporting data sheets were placed in the hands of Statewide Planning citizens to foster ready ascertainment of the quantitative local picture on a county-wide basis.

Orientation sessions for new groups coming into the study, briefings from time to time as the need arose, seminars, workshops, and consultative services were arranged for and conducted. Attendance at Regional meetings of all sorts by the staff of the Central Office contributed to the continuity and dissemination of knowledge about the project. The total information gathered, and the resultant enlightment concerning the rehabilitation concept, is considered to be an important achievement. These widely scattered, numerous, strategically situated citizens are the ones who conducted the study, analyzed their findings, drew conclusions, and submitted recommendations. They have laid the foundations for the subsequent implementation that will evolve; and each of them will continue to be a valuable source of public information and public relations in his own neighborhood, community, and region.

B. Public Information Support: Bureau of Vocational Rehabilitation

The Public Information section of the Bureau of Vocational Rehabilitation has provided continuous support throughout the two-year study, in the form of numerous releases to radio, newspapers, and television, and in frequent feature stories in the Bureau publications BVR Newsletter and Rehabilitation News and Views.

In addition, several special projects were made possible through the efforts of BVR staff members serving with the Public Information Section.

Over 4,000 pamphlets describing the two-year study and highlighting the rehabilitation concept were distributed.

A feature on Statewide Planning for Vocational Rehabilitation appeared in the April, 1968 issue of the state magazine Wonderful World of Ohio.

Public information staff members presented a series of talks, accompanied by slide showings, to interested groups.

Statewide Planning sponsored an exhibit at the National Rehabilitation Association Meeting in Cleveland during the first week in October, 1967. Recently, public information staff members coordinated the construction of a permanent exhibit, featuring automatic slide presentation, graphic panels, and a section illuminated through alternating lighting. The exhibit has been on display at the Center of Science and Industry in Columbus, at the Ohio State Fair 1968, and at several meetings and conventions of professionals in related fields.

Members of the Bureau's public information staff wrote a movie script and coordinated production of the 30 minute color film "For People Too." Sponsored by Motorists Mutual Insurance Company, the film has been shown as a public service on several TV stations in Ohio, and has been scheduled for many others. The film is also available to professional, civic, and church groups upon request.

The Public Information section of the Bureau was responsible for obtaining television and press coverage of the Governor's Council meeting June 27.

TIMETABLE AND CRITICAL PATH OF STUDY ACTIVITY

A. Timetable -- Major Activities and Reports

Meetings of the Governor's Council

December 2, 1966	General Session
May 12, 1967	General Session - Executive Committee Meeting
October 5, 1967	General Session
March 7, 1968	General Session - Council Accepted: Harbridge House Report; Greenleigh Assoicates Report; Seven Regional Reports. Council Adopted: Recommendation on Continuation for Third Year.
June 27, 1968	General Session - Council Adopted: Master Plan/Major Recommendations as given in Chapter II. Council Accepted: Materials to be incorporated into Final Report.
September 5, 1968	Meeting Program Planning Committee Legislation and Finance Committee (as established in Recommendations V and VI, Chapter II).
September 24, 1968	Governor's Council Banquet; Presentation of 8-Volume Final Report to the Governor.

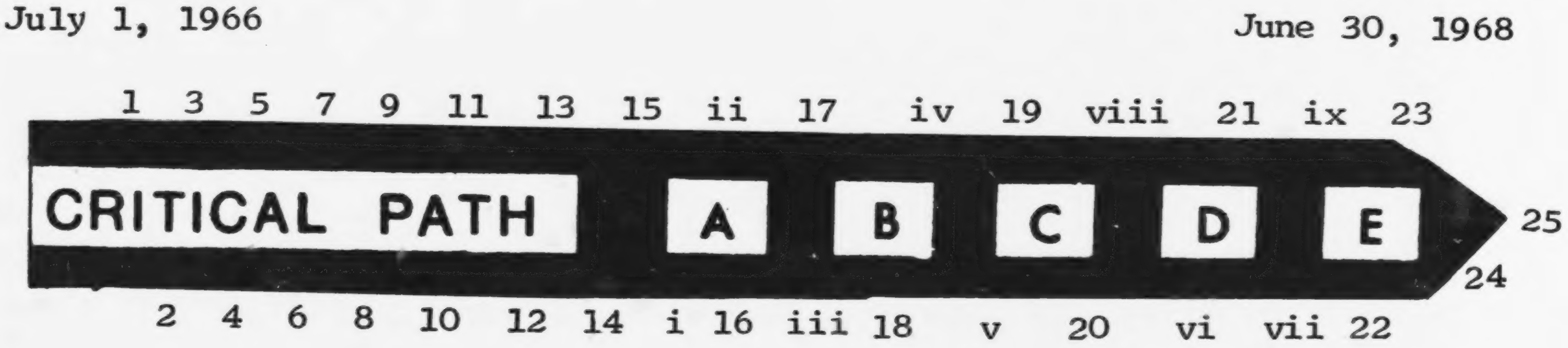
Report to the Governor's Council

First Interim Progress Report - July 1, 1966 to December 31, 1966.
Abstracts of Seminar Series (6) April, 1967.
Abstracts of Workshops (7) June, 1967.
Annual Progress Report - July 1, 1966 to July 1, 1967;
Presented May 12, 1967.
Eighteen Month Report - July 1, 1966 to January 1, 1968;
Presented March 1, 1968.
Report on Two-Year Study - July 1, 1966 to June 30, 1968;
Final Study Recommendations Presented
And Adopted by the Council June 27, 1968.

B. Critical Path of Study Activity

1. Governor's Council appointed.
2. Ohio Statewide Plan adopted.
3. BVR & BSB support organized.
4. Central Office Staff selected.
5. Regional Coordinators appointed.
6. Regional Citizens Committees and Task Forces organized.
7. Task Force Guidelines distributed.
8. Orientation Manual distributed.
9. Information Exchange with other Statewide Planners.
10. Materials and Questionnaires made available.
11. VRA Region V involvement.
12. 1st Interim Report to Washington, May '67.
13. Position Paper Reference Material distributed.
14. Data gathering and Statistical support.
15. Task Force Chairmen Seminar Series.
16. Annual Report - Ohio Statewide Planning.
17. Task Force Chairmen Workshops and distribution of minutes.
18. Central Office Processing.
19. Initial Regional Reports due in Central Office.
20. Compilation of Regional Reports into 18 Month State Report.
21. 18-Month Report to Washington, December '67.
22. Final Regional Reports due in Central Office, March '68.
23. Governor's Council Meeting June '68.
24. Compilation of Final Comprehensive State Report.
25. Implementation of Two-Year Study.
    - A. Telephone Survey/Follow-up.
    - B. Harbridge House agency study.
    - C. Social Security data exploitation.
    - D. Information Retrieval System.
    - E. Greenleigh Study.
    - i. "Toledo Project" Regional Report.
    - ii. 88 County Reference File.

iii. Statewide Planning Directory.
iv. Multihandicapped study.
v. Region III OASDI study.
vi. Lavin-Greenleigh Schedule.
vii. Ad Hoc Committee on Aging.
vii. Migratory Worker study report.


July 1, 1966
June 30, 1968
1 3 5 7 9 11 13 15 ii 17 iv 19 viii 21 ix 23
CRITICAL PATH
A
B
C
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IMPLEMENTATION OF STUDY

A. Statewide Implementation

On the basis of the major recommendations adopted by the Governor's Council on June 27, 1968, Governor James A. Rhodes extended the Council through September 30, 1968 with responsibility for drafting proposals for the legislation necessary to establish the Ohio Rehabilitation Services Commission, and for providing a basis upon which fiscal requirements and the consequent necessary appropriations may be determined.

The Program Planning Committee and the Legislation and Finance Committee of the Governor's Council are scheduled to convene in Columbus September 5, 1968. Following that meeting, a Statewide Vocational Rehabilitation Planning Conference will be held September 12 for BVR Regional Supervisors and Regional Coordinators, to determine action for the remainder of FY 1969 and planning for the next biennium, and to discuss orientation, guidelines, and timetables, within the framework of the recommendations of the Governor's Council.

Agreements are being negotiated by the Bureau of Vocational Rehabilitation with state leaders in rehabilitation to serve as consultants and coordinating staff members in the implementation of the study recommendations.

The Bureau of Vocational Rehabilitation has made application for a Federal planning grant to support the planning stages of a project to develop a statewide information network through the application of computer science to data gathering, data processing, and data retrieval. The planning proposals have been submitted; the coordinator for this project is developing staff and consultant support to implement the planning stages of the project.

B. Regional Implementation

The 18-Month Report of Ohio Comprehensive Statewide Planning indicated a need for a regional rehabilitation planning council in each of the seven planning regions, to establish continuity between the two-year study of regional needs and implementation of those recommendations derived from that regional study.

Such a council would provide the necessary coordination of regional action within the context of statewide implementation of study recommendations, and would serve as an ongoing regional planning body for the delivery of community-based services within the region's multi-county area.

1. Community-Based Sponsorship

Regional Citizens' Committees, in examining the needs of the disabled and disadvantaged throughout the two-year study in their respective regions, found that needs and goals vary. Some individuals require services directed toward functional independence at home or in an institution; others may become employed in sheltered settings. Perhaps the most self-satisfying goal for the client is that of remunerative employment, the rehabilitation objective for all clients whose employment potential makes such a goal feasible.

As a planned program of comprehensive services, vocational rehabilitation calls into play medical, psychological, and social, as well as vocational, services, thereby involving a significant proportion of the professional health and human services programs, agencies, and manpower in any area. The comprehensive goals of rehabilitation make it improbable that any single-goal oriented agency would be in a position to plan for, and coordinate, the diversified services of the many agencies dealing with a variety of health, rehabilitation, and welfare needs in the area.

Because geographic areas themselves differ in available services, and because validity of planning for services to individual clients decreases with distance from the individual in need, local resources and needs must be planned with a comprehensive overview. Therefore, a regional rehabilitation planning council, with local, community-oriented sponsorship, is viewed as essential to effective and efficient implementation.

2. Support of Community-Based Council by Bureau of Vocational Rehabilitation

The 18-Month Report of Ohio Comprehensive Statewide Planning also proposed that a regional rehabilitation planning coordinator be directly responsible to the planning council as Executive

Secretary, and serve as a community-based liaison between the planning council and all rehabilitation services, related agencies, and organizations in that Region.

The Bureau of Vocational Rehabilitation has agreed to support such a coordinator, who, although salaried by the Bureau and administratively responsible to it, would be housed in the community and would function largely within the community rather than within the specific confines of the Bureau operations and jurisdiction. The Coordinator, to be named by mutual agreement between the Bureau and the planning council, would give full-time staff support to the work of the planning council in areas such as comprehensive public education and community public relations programming, coordination of rehabilitation planning with planning in other human services areas being conducted within the region, implementation of planning toward a regional information network and network of services and facilities.

The work of the regional coordinator and the planning council will enable the Bureau to apply the state agency rehabilitation program more effectively and to a greater number of those needing service, through increased knowledge gained from regional inter-agency referral systems and through increased public support arising from better understanding of the Bureau's program.

C. Method for Providing Statewide and Regional Implementation

As stated in Recommendation Four (Chapter II Master Plan), the present Regional Citizens' Committees will adjust to form these regional rehabilitation planning councils, to be known as Regional Advisory Councils, and will receive statewide support and coordination from the State Advisory Council on Rehabilitation Services. This statewide coordinating body will derive from the present Governor's Council on Vocational Rehabilitation.

Planning for the implementation stages of these bodies is now in progress, with specific steps being taken to obtain local sponsorship for the planning council in each region, and to name the regional coordinator for the planning councils.

APPENDICES

APPENDIX I

Categories of RSA Disability Codes

A. RSA DISABILITY CODING STRUCTURE

The new disability coding structure, which gives considerably more detail than previous ones, is based on the WHO International Classification of Diseases (except for mental retardation). It combines disability with cause in a three-digit code, and is organized so that it lends itself easily to summary reporting.

However, it is not always the etiological factor, or the actual pathology, that constitutes the handicap to employment which must be reduced, or removed, before a disabled person can be placed in employment or restored to the highest level of adjustment in terms of work or his activities of daily living.

Hence, from a nosological aspect, the BVR categories are not easily understood, nor appreciated, except by those working in vocational rehabilitation. However, for the purposes of this study, and in order to get the maximum usage from BVR data, and for those planning for vocational rehabilitation, these BVR categories (RSA Disability Codes) were used extensively.

Whenever possible, data was adjusted to conform to these categories, the two-digit collapsed code proving particularly functional.

B. Categories of RSA DISABILITY CODES

RSA (VR)Code No.	
10 - 11	Blind (legally)
12 - 14	Visual Impairments (other than legally blind)
20 - 22	Deafness (all acoustical disabilities)
30 - 39	Orthopedic Multiple Sclerosis Cerebral Palsy Muscular Dystrophy Similar Related Impairments
40 - 44	Absence and Amputation - Major/Minor members
50	Mental (psychotic)
52	Personality Disorders Alcoholism Drug Addiction "Social Offenders", etc.
53	Mental Retardation
60	Neoplasms
61	Allergies - Endocrine - Nutritional-Metabolic
62	Blood - Vascular
63	Epilepsy (630) - Neurological (639)
64	Cardiac
65	Respiratory
66	Digestive
67	Genito-Urinary
68	Speech Impairments
69	No elsewhere classified (NEC)

C. METHOD OF ASSIGNING RSA DISABILITY CODES

All RSA codes from 100 through 449 pertain to disabling conditions and their related etiologies which affect specified parts of the body. For these codes, the first two digits always pertain to the disabling condition itself, and the last digit refers always to the cause of the condition. Thus, if a client was disabled because he was missing at least one upper and one lower extremity (40-) due to an accident, injury, or poisoning (--9), the RSA code would be 409.[1]

RSA Code	WHO Reference	
(4--)	--	ABSENCE OR AMPUTATION OF MAJOR AND MINOR MEMBERS[2]
(40-)		Loss of at least one upper and one lower major extremity (including hands, thumbs, and feet), due to:
400	--	malignant neoplasms
402	Y73.7-.8	congenital malformation
404	Y70.7-.8, Y71.7-.8 Y72.7-.8, Y74.7-.8	diseases, infectious and non-infectious (including peripheral vascular, diabetes, tuberculosis of bones and joints), and infections (including gangrene).
409	Y75.7-79.7 Y75.8-79.8	accidents, injuries, and poisonings

RSA codes from 500 through 699 pertain to disabling conditions where specific body sites are not involved and etilogy is not usually appropriate. These codes are not to be used if the disabling condition is a visual, hearing, or orthopedic impairment, or an amputation (RSA codes 100-499). For example, if diabetes, has led to an amputation of both legs, the proper code would be RSA 434 rather than RSA 614.[1]

(43-)		Loss of one or both major lower extremities[2] (including feet), due to:
430	--	malignant neoplasms
432	Y73.5	congenital malformation
434	Y70.5-72.5	diseases, infectious and non-infectious (including peripheral vascular, diabetes, tuberculosis of bones and joints), and infections (including gangrene).
439	Y75.5-79.5	accidents, injuries, and poisonings

The code for diabetes (RSA 614) would be used only when the disability is not significantly associated with the eyes, ears, limbs, digits, or trunk, and the diabetes, itself, is the condition that contributed primarily toward the work limitation.[1]

(61-)		Allergic, endocrine system, metabolic[2] and nutritional diseases
610	240-41	hay fever and asthma
611	242-45	other allergies
614	260	diabetes mellitus
615	250-54, 270-77	other endocrine system disorders
619	280-82, 286-89	avitaminoses and other metabolic diseases

Cases may occasionally involve two codes in the 500 through 699 series such as a benign neoplasm (RSA code 609) leading to a cardiac condition (RSA 643). In this case use RSA code 643. The rule of thumb is this: try to make a distinction between condition and cause and use the code related to the condition. A condition would be more directly associated with the work limitation than would a cause.[1]

(5--)	--	MENTAL, PSYCHONEUROTIC, AND PERSONALITY DISORDERS[2]
(6--)		OTHER DISABLING CONDITIONS FOR WHICH ETIOLOGY IS NOT KNOWN OR NOT APPROPRIATE
(60-)		Other conditions resulting from neoplasms (n.e.c.):
600	--	colostomies resulting from malignant neoplasms
601	--	laryngectomies resulting from malignant neoplasms
602	204	leukemia and aleukemia
605	140-152, 155-160. 162-203.205	other malignant neoplasms
(609	210-239	benign and unspecified neoplasms)
(64-)		Cardiac and circulatory conditions:
640	--	congenital heart disease
641	400-02, 410-16	rheumatic fever and chronic rheumatic heart disease
642	420-22	arteriosclerotic and degenerative heart disease
643	430-34	other diseases or conditions of heart

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[1] Vocational Rehabilitation Manual, "DISABLING CONDITION - GENERAL INSTRUCTIONS", June, 1966. NOTE: "VRA" has been changed to read "RSA" for purposes of this report.

[2] Vocational Rehabilitation Manual, Statistical Reports, "CLASSIFICATION OF DISABLING CONDITIONS AND CAUSES", June, 1966 pp. 13-2-21 ff.

D. KEY to OLD and NEW BVR DISABILITY CODES

NEW	DISABILITY CLASSIFICATION	OLD
10	Blindness, both eyes - no light	13)
11	Blindness, both eyes - correction not more than 20/200	)
12	Blindness, one eye, other eye defective	)
13	Blindness, one eye, other eye good	14)
14	Other visual impairments - cataract, glaucoma	)
20	Deafness -	)
21	Deafness -	15-16-17)
22	Other hearing impairments	)
30-31	Impairment-3 or more limbs-polio, M.D., M.S., C.P.	09
32-33	Impairment-1 upper and one lower-C.P. birth injury	09
34-35	Impairment-1 upper or both upper limbs	05-06
36-37	Impairments-one or both lower extremities	07-08
38-39	Ill-defined impairments - trunk, back, spine	00-01-02-03
40	Absence or amputation or major and minor members	04
50	Mental, Psychoneurotic & Personality Disorders	19
52	Other mental disorders	30
53	Mental Retardation	20
60	Other disabling conditions - neoplasms	24
61	Other disabling conditions - allergic, endocrine	24

NEW	DISABILITY CLASSIFICATION	OLD
62	Other disabling conditions - blood	24
64	Other disabling conditions - cardiac	21
65	Other disabling conditions - respiratory	23
66	Other disabling conditions - digestive	24
67	Other disabling conditions - genito-urinary system	24
68	Other disabling conditions - speech impairment	18
69	Other disabling conditions - n.e.c.	24
63	Epilepsy (under disorders of the nervous system)	

Form VR-300—7/66

E. SAMPLE VR - 300

CLOSED CASE RECORD

PART 1 REFERRAL (To be completed for all closures)

A. Client's Name -- (Last) -- (First) -- (Initial) Case No. --

B. Address -- (Street and number) -- (City) -- (State) -- (County)

Counselor Code -- District Code 09 County Code 70

C. Referral date 3/15/60 D. Referral Source 43 * Age 16 F. Sex: 1. ☒ Male 2. ☐ Female

G. Disability as reported (describe) Amputation Fingers and Half of Right Hand and Thumb

Code 429 *

PART 2 SECTION I (Complete for all Closures)

A. Date referral process completed 1/9/61

B. Number of months in status 00 and 02 10

C. SSDI status at referral 0 *

D. Complete this item for males 17-26 only.
Selective Service rejectee:
1. ☐ Yes; 2. ☐ No; 3. ☐ NR

F. Outcome of referral process:

Not accepted: Reason ______ *

1. ☐ From status 00; 2. ☐ From status 02

03 ☐ Accepted, 6-mos. Ext. Eval. 04

04 ☐ Accepted, 18-mos. Ext. Eval. 06

05 ☒ Accepted for VR Services

PART 2 SECTION II (Complete for all persons coded 03, 04, or 05 in Item F of Section I)

G. Social Security No. --

H. Race 1 *

I. Marital status 5 *

J. Number of dependents 0

K. Highest grade of school completed 12

L. Primary source of support 01 *

M. Weekly earnings (Nearest dollar) $ 000

N. Work status 7 *

O. Type and monthly amount of PA to nearest dollar $ 000 Type 0 *

P. Previously accepted for VR services:
1. No ☒ 2. Yes ☐ If yes,
Closed: 1. ☐ Rehab. 2. ☐ Not Rehab.
If yes, months from last closure to current acceptance ______ (months)

Q. SSDI status at acceptance 0 *

R. Disabling conditions (describe)

1. Major Amputation Fingers-Half of Right Hand and Thumb

Code 429 *

2. Secondary None

Code 999 *

PART 3 REPORT OF COMPLETED EXTENDED EVALUATION PROCESS

B. Outcome of extended evaluation:

1. ☐ Accepted for VR services

2. ☐ Not accepted; Reason ______ *

If not accepted, check benefits received*;
00 ☐ ; 01 ☐ ; 02 ☐ ; 04 ☐ ; 10 ☐ ; 20 ☐

Sum of checked benefits codes ______

C. Date extended evaluation completed ______

D. Number of months in extended evaluation

______ (months)

E. SSDI status at extended evaluation completion

______ *

PART 4 REPORT OF COMPLETED CASE SERVICES

A. VR service outcome:

1. ☒ Rehabilitated (status 26)
2. ☐ Not rehab. (status 28) Reason ______*
3. ☐ Not rehab. (status 30) Reason ______*

B. Check benefits received since referral*;

00 ☐ ; 01 ☐ ; 02 ☒ ; 04 ☒ ; 10 ☒ ; 20 ☐

Sum of checked benefits codes 16

C. SSDI status at time of closure 0 *

D. Number of months on agency rolls:

1. Acceptance to closure (statuses 10-24) 73
2. Pre-service (statuses 10-12) 20
3. Counseling & guidance only (status 14) 0
4. In service (statuses 16-18) 30
5. Ready for employment (status 20) 0
6. In employment (status 22) 2

E. Type and monthly amount of public assistance to the nearest dollar:

$ 000 Type 0

F. Work status 1 *

G. Weekly earnings (nearest dollar):

$80

H. Occupation at closure Radiologic Technologist

Code 0783 *

FOR STATE OFFICE USE ONLY

Cost of Case Services

Type of Service	Type of Facility								
	Cost of diagnostic services while in statuses 00 and 02			Cost of services during extended evaluation			Cost of services during VR process		
	Rehab. Centers	Workshop	Other	Rehab. Centers	Workshop	Other	Rehab. Centers	Workshop	Other
Diagnostic Procedure			8						
Physical Restoration									
Training & Materials									855
Maint. & Transport.									847
Training Allowances									
Other Services									
TOTAL			8						1702

Closure remarks:

The client, who lost his fingers and thumb of the right hand in an I.C. accident while still in high school, has satisfactorily completed his training, as X-ray Technician at ----- Hospital, -----, Ohio. ----- was an excellent student, and he will now be employed full time, as a technician in the Radiology Department, ----- Hospital. His salary will be $80.00 per week.

Date of Closure -/-/67

Counselor's Signature ---

Approved by ---

APPENDIX II

ESTIMATED POPULATION by COUNTY and SELECTED AGE GROUPS, OHIO, JANUARY 1, 1965

County	Population			Percent of		
				County Pop		State Pop
	Total[a]	45-64[b]	65 yrs[b] & older	45-64 years	65 yrs & older	65 yrs & older
Ohio	10,501,234	2,047,741	966,114	19.5	9.2	100.0
ADAMS	19,486	4,050	2,780	20.8	14.3	0.3
ALLEN	110,512	21,330	10,500	19.3	9.5	1.1
ASHLAND	41,218	8,040	4,580	19.5	11.1	0.5
ASHTABULA	99,205	19,740	10,020	19.9	10.1	1.0
ATHENS	47,654	8,960	5,810	18.8	12.2	0.6
AUGLAIZE	38,434	7,150	4,190	18.6	10.9	0.4
BELMONT	80,820	17,940	10,570	22.2	13.0	1.2
BROWN	26,710	5,480	3,390	20.5	12.7	0.4
BUTLER	222,714	38,980	15,810	17.5	7.1	1.6
CARROLL	21,588	3,930	2,360	18.2	11.0	0.3
CHAMPAIGN	30,798	5,850	3,450	19.0	11.2	0.4
CLARK	139,944	27,430	14,080	19.6	10.1	1.5
CLERMONT	100,853	15,230	6,560	15.1	6.5	0.6
CLINTON	32,207	5,930	3,740	18.4	11.6	0.4
COLUMBIANA	109,120	22,040	11,570	20.2	10.6	1.3
COSHOCTON	32,788	6,790	3,900	20.7	11.9	0.4
CRAWFORD	50,854	9,560	5,590	18.8	11.0	0.6
CUYAHOGA	1,751,402	378,300	166,130	21.6	9.2	16.8
DARKE	47,391	9,150	5,690	19.3	12.0	0.6
DEFIANCE	34,227	5,790	3,390	16.9	9.9	0.3
DELAWARE	38,984	7,170	4,020	18.4	10.3	0.4
ERIE	75,552	14,580	7,400	19.3	9.8	0.7
FAIRFIELD	69,723	13,670	7,110	19.6	10.2	0.7
FAYETTE	25,737	4,970	3,140	19.3	12.2	0.3
FRANKLIN	774,338	139,380	61,170	18.0	7.9	6.0
FULTON	30,812	5,670	3,330	18.4	10.8	0.4
GALLIA	26,598	5,510	2,900	20.7	10.9	0.3
GEAUGA	58,257	9,500	3,960	16.3	6.8	0.4
GREENE	112,292	15,720	6,180	14.0	5.5	0.6
GUERNSEY	38,706	8,520	6,120	22.0	15.0	0.7

	Population			Percent of		
COUNTY	Total[a]	45-64[b]	65 yrs.[b] & older	County Pop.		State Pop.
				45-64 years	65 yrs. & older	65 yrs. & older
HAMILTON..	932,154	194,820	89,490	20.9	9.6	9.2
HANCOCK...	58,328	11,080	6,420	19.0	11.0	0.7
HARDIN....	29,772	5,630	3,630	18.9	12.2	0.4
HARRISON..	17,195	3,610	2,150	21.0	12.5	0.2
HENRY......	26,838	5,130	3,090	19.1	11.5	0.3
HIGHLAND..	30,264	6,330	4,210	19.0	11.5	0.4
HOCKING...	20,513	4,060	2,400	19.8	11.7	0.3
HOLMES....	22,985	3,860	2,440	16.8	10.6	0.3
HURON.....	50,776	9,190	5,330	18.1	10.5	0.6
JACKSON...	29,511	5,610	3,390	19.0	11.5	0.4
JEFFERSON.	98,863	20,960	9,190	21.2	9.2	1.0
KNOX......	40,040	8,170	4,760	20.4	11.9	0.5
LAKE......	185,954	29,570	10,410	15.9	5.6	0.9
LAWRENCE..	58,046	10,910	5,170	18.8	8.9	0.5
LICKING...	100,169	19,130	10,420	19.0	10.4	1.0
LOGAN.....	36,045	6,990	4,510	19.4	12.5	0.5
LORAIN....	251,509	42,760	18,110	17.0	7.2	1.8
LUCAS.....	481,642	102,590	47,200	21.3	9.8	5.0
MADISON...	28,477	4,960	2,510	17.4	8.8	0.3
MAHONING..	315,113	63,340	29,940	20.1	9.5	3.1
MARION....	64,810	11,990	6,680	18.5	10.3	0.7
MEDINA....	77,547	12,800	6,130	16.5	7.9	0.6
MEIGS.....	21,536	4,310	2,910	20.0	13.5	0.3
MERCER....	34,099	6,210	3.510	18.2	10.3	0.4
MIAMI.....	78,202	15,090	7,590	19.3	9.7	0.8
MONROE....	15,488	3,110	2,170	20.1	14.0	0.2
MONTGOMERY	585,763	107,780	43,930	18.4	7.5	4.4
MORGAN....	12,599	2,510	1,860	19.9	14.8	0.2
MORROW....	20,470	3,850	2,230	18.8	10.9	0.2
MUSKINGUM.	80,720	16,230	8,960	20.1	11.1	1.0
NOBLE.....	10,406	2,180	1,560	20.9	15.0	0.2
OTTAWA....	37,632	7,260	3,690	19.3	9.8	0.4

	Population			Percent of		
				County Pop.		State Pop.
County	Total[a]	45-64[b]	65 yrs. & older[b]	45-64 years	65 yrs. & older	65 yrs. & older
PAULDING	17,544	3,130	1,880	17.8	10.7	0.2
PERRY...	27,227	5,530	3,620	20.3	13.3	0.4
PICKAWAY	39,639	6,740	3,490	17.0	8.8	0.4
PIKE....	21,298	3,490	1,810	16.4	8.5	0.2
PORTAGE.	106,045	16,650	7,640	15.7	7.2	0.7
PREBLE..	35,021	6,270	3,470	17.9	9.9	0.4
PUTNAM..	29,744	5,120	3,030	17.2	10.2	0.3
RICHLAND	129,969	23,910	10,400	18.4	8.0	1.0
ROSS....	64,306	11,900	6,370	18.5	9.9	0.7
SANDUSKY	60,723	11,050	6,190	18.2	10.2	0.6
SCIOTO..	83,247	17,400	8,660	20.9	10.4	1.0
SENECA..	61,754	11,300	6,610	18.3	10.7	0.7
SHELBY..	35,890	6,530	3,590	18.2	10.0	0.4
STARK...	363,692	72,010	34,550	19.8	9.5	3.6
SUMMIT..	558,934	113,460	45,830	20.3	8.2	4.7
TRUMBULL	230,609	42,430	18,220	18.4	7.9	1.8
TUSCARAWAS	78,961	15,950	8,920	20.2	11.3	1.0
UNION	23,749	4,610	2,850	19.4	12.0	0.3
VAN WERT	29,151	5,740	3,670	19.7	12.6	0.4
VINTON	9,868	1,910	1,120	19.3	11.3	0.1
WARREN	79,850	11,580	5,110	14.5	6.4	0.5
WASHINGTON	55,118	10,360	6,450	18.8	11.7	0.7
WAYNE	83,648	14,640	7,860	17.5	9.4	0.8
WILLIAMS	31,659	6.050	3,770	19.1	11.9	0.4
WOOD	78,952	14,230	7,110	18.1	9.0	0.7
WYANDOTTE	22,246	4,230	2,650	19.0	11.0	0.3

(a) Population estimates by Ohio Department of Development.
(b) County figures rounded to nearest tenth.
(c) 1960 Census percentages for specified age groups have been applied to estimated total population for 1965.

Note: Because percentages are rounded to nearest tenth, county population figures will not add to the State total which is also a calculated figure.

Prepared by: Bureau of Research and Statistics, Division of Business Administration, Department of Mental Hygiene and Correction, December 9, 1965.

APPENDIX III

PREVALENCE OF DISABILITIES

RSA REGION V - TELEPHONE SURVEY RESULTS

Illinois-Indiana-Michigan-(Minnesota)-Ohio-Wisconsin

Prevalence of Disabilities in the Age Group 14-65
Per 1,000 Population Using Collapsed Disability Code

A. RSA - REGION V STATES (+ MINNESOTA)

Prevalence of Disabilities Per 1,000 Population by Disability Categories

Disability Category	RSA (VRA) Codes	Regional Average	ILL.	IND.	MICH.	MINN.	*OHIO	WIS.
Orthopedic & Functional Imp.	05-18, 53-54	105.37	118.29	113.09	89.94	115.81	87.5	121.6
Diabetes	26	15.42	15.16	16.15	16.38	8.75	16.8	18.2
Visual Imp.	01-02	13.70	11.01	14.57	14.53	12.25	14.5	16.6
Hearing & Speech Imp.	03-04 47-51	14.97	13.84	12.67	15.14	19.24	11.64	21.2
Cardiac & Circulatory Disorders	29-33	63.06	50.40	48.92	59.03	49.29	53.85	62.0
Respiratory Disorders	24, 35-40	52.03	56.31	53.53	46.99	48.42	50.0	53.1
Mental & personality Disorders (including alcoholism)	19-21	29.14	34.67	32.31	23.18	23.34	28.1	32.6
Mental Retardation	22	1.54	1.26	0.95	0.31	1.46	2.3	3.2
Other	23, 25 27-28,34 41-46,52	95.31	107.03	104.51	89.21	91.89	79.3	105.6

*Ohio - 10,700,000 Total Population = 10,700 x (figure shown for disability prevalence per 1,000) = Estimated number of persons in Ohio in Disability Category listed.

B. RSA - REGION V STATES (+ MINNESOTA)

Prevalence of Disabilities Per 1,000 Population
By (VRA) RSA Codes

Code	Disability	Regional Average	ILL.	IND.	MICH.	MINN.	*OHIO	WIS.
01	Blindness in both eyes	0.73	1.26	0.63	0.62	0.58	0.32	0.82
02	Other Visual imp.	12.97	9.75	13.94	13.91	11.67	14.2	15.79
03	Deafness	2.20	0.63	1.58	2.78	4.08	1.6	4.63
04	Other hearing imp.	10.23	10.70	9.50	10.20	11.08	8.1	13.34
05	Congenital malformation	2.24	4.09	3.17	1.54	2.33	0.97	1.09
06	Arthritis & rheumatism	30.48	35.24	31.68	29.68	27.13	27.8	28.59
07	Poliomyelitis	1.28	0.63	1.27	1.54	1.75	0.65	2.99
08	Stroke	3.23	6.61	0.32	2.78	2.04	1.9	2.99
09	Other orthopedic conditions	57.57	64.82	67.47	45.44	69.14	42.6	72.15
10	Epilepsy	1.96	1.26	1.58	1.54	1.75	3.2	2.18
11	Cerebral palsy	0.45	0.00	0.00	0.93	0.58	0.65	0.54

*Ohio - 10,700,000 Total Population = (10,700 x figure shown for disability prevalence per 1,000) = Approximate number of persons in Ohio having disability described.

Code	Disability	Regional Average	ILL.	IND.	MICH.	MINN.	*OHIO	WIS.
12	Muscular dystrophy	0.07	0.00	0.00	0.00	0.00	0.00	0.54
13	Multiple sclerosis	0.45	0.31	0.00	0.62	1.17	0.32	0.54
14	Parkinson's disease	0.35	0.31	0.32	0.00	0.58	0.65	0.27
15	Other disorders of the nervous system	3.36	3.46	2.53	1.54	5.25	3.6	4.90
16	Amputation of upper extremity	1.51	0.31	0.95	1.24	0.88	2.9	2.72
17	Amputation of lower extremity	0.79	0.31	0.95	0.62	0.58	1.3	1.09
18	Amputation of upper & lower extremity	0.00	0.00	0.00	0.00	0.00	0.00	0.00
19	Psychotic & psychoneurotic disorders--mental illness, nervousness	27.64	34.04	30.41	21.64	21.30	26.5	30.49
20	Alcoholism	1.50	0.63	1.90	1.54	2.04	1.6	2.18
21	Drug addiction	0.00	0.00	0.00	0.00	0.00	0.00	0.00
22	Mental retardation	1.54	1.26	0.95	0.31	1.46	2.3	3.27
23	Cancer	4.08	7.55	2.53	4.02	3.50	1.9	2.99
24	Hayfever & asthma	22.07	24.23	21.54	20.40	23.92	18.4	23.69
25	Other allergies	16.50	19.19	20.90	12.98	17.79	13.6	17.15

Code	Disability	Regional Average	ILL.	IND.	MICH.	MINN.	*OHIO	WIS.
26	Diabetes	15.42	15.16	16.15	16.38	8.75	16.8	18.24
27	Other endocrine disorders	19.34	19.82	18.69	22.56	16.63	18.4	17.70
28	Diseases of the blood and blood-forming organs	4.84	4.72	6.65	4.94	6.13	2.6	6.53
29	General cardiac & circulatory conditions, NFS	21.45	15.16	23.76	22.87	17.79	25.8	26.41
30	Congenital heart disease	0.27	0.31	0.00	0.31	0.29	0.00	0.82
31	Rheumatic fever & chronic rheumatic heart condition	3.75	2.83	4.43	3.71	5.25	3.2	4.90
32	Arteriosclerotic & degenerative heart disease	1.16	1.26	0.95	1.85	0.29	0.65	1.63
33	Hypertensive heart disease	33.88	30.84	29.78	30.29	25.67	24.2	28.31
34	Varicose veins & hemorrhoids, phlebitis	2.55	3.78	2.53	1.85	2.92	1.30	3.27
35	Tuberculosis	0.82	0.63	0.95	0.62	2.04	0.65	0.82
36	Emphysema	3.47	2.20	4.43	4.33	3.50	4.2	2.45
37	Pneumoconiosis & asbestosis	0.15	0.31	0.00	0.00	0.00	0.32	0.00

Code	Disability	Regional Average	ILL.	IND.	MICH.	MINN.	*OHIO	WIS.
38	Bronchiectasis	0.40	0.31	0.63	0.00	0.00	0.32	0.82
39	Chronic bronchitis and sinusitis	18.85	22.34	19.64	17.00	13.42	18.7	18.24
40	Diseases of the respiratory system NFS	6.27	6.29	6.34	4.64	5.54	7.4	7.08
41	Conditions of teeth & supporting structures	0.65	0.00	0.63	1.85	0.58	0.00	1.36
42	Ulcer of stomach & duodenum	10.49	11.96	9.50	10.72	10.50	8.1	13.34
43	Chronic enteritis & ulcerative colitis hernia	0.61	0.94	0.32	0.62	0.88	0.00	1.09
44	Colostomies, colitis	1.92	2.20	2.22	1.54	1.46	1.30	0.82
45	Other conditions of digestive system	9.79	11.33	13.94	7.42	12.25	7.8	8.71
46	Conditions of genito-urinary system	13.70	15.16	15.20	12.98	9.33	12.0	19.06
47	Cleft palate and/or harelip	0.28	0.31	0.32	0.00	0.58	0.32	0.27
48	Stammering & stuttering	1.37	1.57	0.32	2.16	2.33	0.32	1.91
49	Laryngectomies	0.03	0.00	0.00	0.00	0.00	0.00	0.00

Code	Disability	Regional Average	ILL.	IND.	MICH.	MINN.	*OHIO	WIS.
50	Aphasia	0.00	0.00	0.00	0.00	0.00	0.00	0.00
51	Other speech impairments	0.86	0.63	0.95	0.00	0.88	1.30	1.09
52	Diseases & conditions of the skin	10.84	10.38	11.40	7.73	9.92	12.3	13.61
53	Paraplegia	0.24	0.00	0.63	0.31	1.17	0.00	0.00
54	Other, e.g., fainting spells	1.39	0.94	2.22	2.16	1.46	0.97	1.09

APPENDIX IV

PROJECTIONS to 1970-75 TELEPHONE SURVEY RESULTS
INCIDENCE of DISABILITIES
for
STATEWIDE and REGIONAL POPULATIONS (ages 14-70)

PROJECTIONS FOR THE STATE

B.V.R. CODE	DISABILITY	Rate/1000	State Projections including only ages (14-70) 1970	1975
30-39	ORTHOPEDIC & FUNCTIONAL DIS.	87.5	684,863	737,233
61	DIABETES	16.8	131,494	141,548
10-14	VISUAL IMPAIRMENTS (including blind)	14.5	113,492	122,170
20-22,68	HEARING & SPEECH IMPAIRMENTS	11.64	91,106	98,073
62,64	CARDIAC & CIRCULATORY DISABILITIES	53.85	421,484	453,713
65	RESPIRATORY	50.0	391,350	421,275
52	MENTAL & PERSONALITY DISORDERS	28.1	291,939	236,757
53	MENTAL RETARDATION	2.3	18,002	19,379
69	OTHER (N.E.C.)	79.3	620,681	668,142

OHIO REGIONAL PROJECTIONS
(Continued)

B.V.R. CODE	Rate/ 1000	REGION I		REGION II		REGION III		REGION IV	
		1970	1975	1970	1975	1970	1975	1970	1975
30-39	87.5	67,760	72,153	154,788	167,738	121,450	131,250	60,279	62,948
61	16.8	13,009	13,853	29,719	32,206	23,318	25,200	11,574	12,086
10-14	14.5	11,229	11,957	25,651	27,797	20,126	21,750	9,989	10,431
20-22,68	11.64	9,014	9,598	20,591	22,314	16,156	17,460	8,019	8,374
62,64	53.85	41,701	44,405	95,261	103,230	74,744	80,775	37,097	38,740
65	50.0	38,720	41,230	88,450	95,850	69,400	75,000	34,445	35,970
52	28.1	21,760	23,171	49,709	53,868	39,003	42,150	19,358	20,215
53	2.3	1,781	1,897	4,069	4,409	3,192	3,450	1,584	1,655
69	79.3	61,410	65,391	140,282	152,018	110,068	118,950	54,630	57,048

OHIO REGIONAL PROJECTIONS
(Continued)

B.V.R. CODE	Rate/ 1000	REGION V		REGION VI		REGION VII	
		1970	1975	1970	1975	1970	1975
30-39	87.5	78,986	85,505	110,034	118,825	91,263	98,700
61	16.8	15,165	16,417	21,185	22,814	17,522	18,950
10-14	14.5	13,089	14,169	18,285	19,691	15,124	16,356
20-22,68	11.64	10,507	11,375	14,678	15,807	12,141	13,130
62,64	53.85	48,610	52,622	67,905	73,128	56,166	60,743
65	50.0	45,135	48,860	63,050	67,900	52,150	56,400
52	28.1	25,366	27,459	35,434	38,160	29,308	31,697
53	2.3	2,076	2,248	2,900	3,123	2,399	2,594
69	79.3	71,584	77,492	99,997	107,689	82,710	89,450

APPENDIX V
OHIO BVR CASELOAD STATISTICS

A. NUMBER OF CASES CLOSED REHABILITATED (BY FISCAL YEAR) 1960-1966

COUNTY	1959-60	1960-61	1961-62	1962-63	1963-64	1964-65	1965-66
Adams	7	1	1	3	6	6	1
Allen	10	33	34	50	55	48	66
Ashland	8	14	22	15	15	20	23
Ashtabula	6	8	20	23	24	17	37
Athens	8	19	16	23	23	19	20
Auglaize	2	6	8	4	8	7	26
Belmont	27	32	32	42	56	53	58
Brown	7	4	4	11	6	10	13
Butler	44	32	40	45	45	26	82
Carroll	0	1	1	2	3	1	2
Champaign	1	3	6	7	6	17	15
Clark	21	27	13	27	38	57	34
Clermont	12	16	23	22	13	31	32
Clinton	2	1	5	5	3	1	7
Columbiana	17	28	48	45	21	40	36
Coshocton	7	11	4	8	21	9	15
Crawford	12	5	16	12	18	16	14
Cuyahoga	257	284	325	324	229	305	391
Darke	5	8	14	20	19	10	24
Defiance	4	3	9	7	14	8	7
Delaware	5	5	8	7	10	10	11
Erie	8	11	13	21	27	24	18
Fairfield	3	11	18	18	15	8	15
Fayette	1	4	7	11	5	7	10
Franklin	187	217	205	205	202	204	263
Fulton	2	4	6	6	5	9	12
Gallia	4	6	10	8	7	8	17
Geauga	4	3	5	2	9	4	7
Greene	5	8	10	5	16	18	20
Guernsey	14	8	10	14	18	19	32
Hamilton	127	122	204	199	139	208	247
Hancock	8	9	20	19	29	28	18
Hardin	1	5	3	2	7	9	15
Harrison	7	6	4	5	6	4	9
Henry	5	5	7	4	6	6	5
Highland	6	6	5	3	4	1	8
Hocking	2	1	8	2	6	3	13
Holmes	0	2	2	1	0	1	3
Huron	4	6	4	14	16	11	24
Jackson	3	3	12	5	12	13	14
Jefferson	23	14	25	22	22	23	27
Knox	7	5	8	18	28	15	33
Lake	19	23	31	40	36	22	20

COUNTY	1959-60	1960-61	1961-62	1962-63	1963-64	1964-65	1965-66
Lawrence	7	2	10	12	23	14	8
Licking	12	13	13	19	34	30	32
Logan	4	6	9	5	11	11	14
Lorain	24	39	58	33	60	43	56
Lucas	130	147	161	190	182	186	188
Madison	4	6	7	7	3	11	11
Mahoning	45	71	81	70	82	98	148
Marion	12	17	15	26	30	20	27
Medina	11	12	9	12	16	15	9
Meigs	3	4	6	4	5	7	10
Mercer	3	7	6	4	17	19	10
Miami	4	14	26	33	35	13	29
Monroe	1	1	4	2	4	3	6
Montgomery	95	78	92	150	132	144	157
Morgan	2	4	4	9	2	8	12
Morrow	2	2	3	9	14	3	6
Muskingum	23	28	39	43	51	53	38
Noble	2	0	0	4	3	7	7
Ottawa	3	6	5	5	10	7	8
Paulding	2	5	6	13	7	4	5
Perry	4	1	6	11	10	7	11
Pickaway	1	5	3	3	8	3	8
Pike	3	1	5	4	1	9	0
Portage	13	17	34	21	25	30	17
Preble	3	3	5	6	11	6	8
Putnam	2	6	9	20	11	11	17
Richland	41	37	28	38	49	67	66
Ross	10	8	15	13	22	16	3
Sandusky	12	10	17	22	36	22	18
Scioto	16	16	33	16	46	27	25
Seneca	9	7	19	24	34	31	41
Shelby	6	2	7	6	8	10	11
Stark	42	50	70	81	63	85	103
Summit	63	125	160	185	169	148	90
Trumbull	29	17	37	27	57	71	95
Tuscarawas	10	11	17	13	11	17	22
Union	6	5	3	7	4	15	8
Van Wert	4	6	9	9	15	2	11
Vinton	4	1	3	2	5	5	5
Warren	7	8	12	9	17	8	18
Washington	6	16	12	13	12	17	15
Wayne	18	17	25	11	13	18	20
Williams	11	4	8	4	5	7	10

COUNTY	1959-60	1960-61	1961-62	1962-63	1963-64	1964-65	1965-66
Wood	8	17	21	16	30	21	17
Wyandot	5	3	3	10	11	9	8
State Total	1,624	1,875	2,391	2,547	2,642	2,704	3,172
% Increase Over Previous Year	15%	27%	6%	3%	2%	17%	16%

* Total 1958-59 = 1508

B. CHARACTERISTICS OF 3,172 CLIENTS REHABILITATED FISCAL YEAR 1965-66[1]

3,172 cases were closed as rehabilitated during fiscal '66 -- a 16% increase over fiscal '65. The average cost per person rehabilitated was $1,340. Characteristics of the 3,172 clients were as follows:

Age	%	#
Under 20	30.1%	953
20-34	37.6%	1,192
35-44	16.2%	515
45-54	10.9%	346
55-64	4.5%	144
65 and over	.7%	22

Sex	%	#
Men	73.5%	2,333
Women	26.5%	839
Dependents		
None	61.6%	1,953
1-3	25.1%	798
4 or more	13.3%	421

Referral Sources	%	#
Educational institutions	20.1%	639
Hospitals and sanatoriums	14.2%	450
Interested individuals	9.2%	292
Other health agencies and rehabilitation centers	9.1%	290
Welfare agencies	8.9%	282
State Employment Service	10.4%	329
Physicians	6.8%	214
Self-referred	7.5%	236
Artificial appliance companies	3.6%	114
Bureau of Old Age and Survivors' Insurance	3.4%	109
Workmen's Compensation	2.4%	77
Other Sources	4.4%	140

Major Disabilities		
Orthopedic deformity or impairment (except amputation)	29.7%	942
Amputation	12.8%	407
Visual loss or impairment	6.3%	200
Deaf, without speech	2.1%	65
Deaf, with speech	1.5%	46
Other hearing impairments	2.7%	87
Speech Impairment	2.4%	76
Mental illness	10.2%	325

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[1] BVR Annual Report Fiscal 1965-66.

Major Disabilities (Continued)

		%	#
Personality, character, and behavior disorders		4.5%	142
Mental retardation or deficiency		8.8%	279
Allergic, endocrine, etc. disorders	(included in other)		
Neoplasms	(included in other)		
Blood diseases, etc.	(included in other)		
Epilepsy and other nervous disorders		4.5%	144
Heart and circulatory conditions		5.3%	169
Respiratory diseases		2.3%	73
Digestive system disorders	(included in other)		
Other disabilities		6.9%	217

Education Level at Acceptance

	%	#
None	.3%	9
1 - 4 years	1.7%	53
5 - 6 years	3.8%	122
7 - 8 years	16.7%	530
9 - 10 years	20.2%	640
11 - 12 years	51.0%	1,619
13 and over	6.3%	199

Source of Support at Acceptance

	%	#
Family and friends	58.5%	1,857
Own income	11.9%	377
Public assistance	10.6%	335
Other benefits and insurance	6.4%	204
Workmen's Compensation	4.3%	135
Public institutions	4.7%	150
Social security disability insurance benefits (not reported)		
Bureau of Old Age and Survivors' Ins.	3.4%	107
Private relief agencies	.2%	7
Not reported	---	

Jobs After Rehabilitation

	%	#
Professional	5.7%	179
Semi-professional and managerial	5.2%	165
Clerical and sales	20.5%	649
Service	17.5%	555
Agricultural and allied work	2.3%	74
Industrial occupations - Skilled	15.6%	494
Semi-skilled	14.2%	452
Unskilled	7.2%	229
Sheltered workshops and vending stands	1.9%	154
Homemakers and unpaid family workers	8.6%	221

C. CHARACTERISTICS OF 3,698 CLIENTS REHABILITATED FISCAL YEAR 1966-67[1]

3,698 cases were closed as rehabilitated during fiscal '67 -- a 17% increase over fiscal '66. The average cost per person rehabilitated was $1,874. Characteristics of the 3,698 clients were as follows:

Age	%	#
Under 20	29.6%	1,095
20-34	35.6%	1,316
35-44	16.6%	613
45-64	17.5%	648
65 and over	.7%	26

Sex	%	#
Men	70.5%	2,609
Women	29.5%	1,089
Dependents		
None	58.7%	2,169
1-3	28.4%	1,051
4 or more	12.9%	478

Referral Sources	%	#
Educational institutions	20.1%	742
Hospitals and sanatoriums	14.4%	533
Interested individuals	9.0%	332
Other health agencies and rehabilitation centers	8.5%	314
Welfare agencies	7.3%	272
State Employment Service	12.3%	452
Physicians	6.3%	233
Self-referred	6.6%	243
Artificial appliance companies	4.4%	162
Bureau of Old Age and Survivors' Insurance	3.8%	139
Workmen's Compensation	2.7%	101
Correctional institutions	1.2%	46
Other sources	3.4%	127

Major Disabilities	%	#
Orthopedic deformity or impairment (except amputation)	26.8%	989
Amputation	13.3%	491
Visual loss or impairment	6.7%	249
Deaf, without speech	1.8%	65
Deaf, with speech	3.0%	110
Other hearing impairments	2.4%	90
Speech Impairment	2.2%	80
Mental illness	10.2%	378

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[1] BVR Annual Report Fiscal 1966-67.

Major Disabilities (Continued)	%	#
Personality, character, and behavior disorders	5.5%	202
Mental retardation or deficiency	10.2%	378
Allergic, endocrine, etc. disorders	2.4%	89
Neoplasms	.2%	9
Blood diseases, etc.	.1%	4
Epilepsy and other nervous disorders	4.2%	155
Heart and circulatory conditions	5.1%	190
Respiratory diseases	1.6%	59
Digestive system disorders	2.5%	92
Other disabilities	1.8%	68

Education Level at Acceptance	%	#
None	.2%	6
1- 7 years	7.2%	267
8 years	11.3%	419
9-11 years	24.1%	819
12 years	38.8%	1,435
13 and over	5.4%	201
Special Ed.	13.0%	479

Source of Support at Acceptance	%	#
Family and friends	56.1%	2,073
Own income	13.9%	513
Public assistance	6.7%	248
Other benefits and insurance	5.4%	198
Workmen's compensation	5.1%	189
Public institutions	7.9%	293
Social security disability insurance benefits	4.4%	164
Private relief agencies	.1%	4
Not reported	.4%	16

Jobs After Rehabilitation		
Professional, technical, and managerial	11.3%	418
Clerical and sales	19.5%	722
Service	20.6%	762
Agricultural and allied work	1.8%	65
Industrial occupations		
Skilled	11.5%	424
Semi-skilled	3.9%	144
Unskilled	20.9%	775
Sheltered workshops and vending stands	1.9%	70
Homemakers and unpaid family workers	8.6%	318

D. CHARACTERISTICS OF 5,616 CLIENTS REHABILITATED FISCAL YEAR 1967-68[1]

5,616 cases were closed as rehabilitated during fiscal '68 -- a 51.9% increase over fiscal '67. The average cost per person rehabilitated has not yet been analyzed. Characteristics of the 5,616 clients were as follows:

Age	%	#
Under 20	28.4%	1,596
20-34	36.7%	2,060
35-44	16.2%	911
45-64	17.9%	1,003
65 and over	0.8%	46

Sex	%	#
Men	66.8%	3,750
Women	33.2%	1,866
Dependents		
None	65.1%	3,658
1-3	24.1%	1,351
4 or more	10.8%	607

Referral Sources	%	#
Educational institutions	20.3%	1,138
Hospitals and sanatoriums	17.9%	1,004
Interested individuals	8.6%	485
Other health agencies and rehabilitation centers	8.3%	465
Welfare agencies	5.8%	326
State Employment Service	10.2%	575
Physicians	4.9%	275
Self-referred	7.2%	402
Artificial appliance companies	3.2%	179
Bureau of Old Age and Survivors' Insurance	4.8%	269
Workmen's Compensation	2.3%	127
Correctional institutions	2.0%	115
Other sources	4.5%	254
Major Disabilities		
Orthopedic deformity or impairment (except amputation)	24.2%	1,361
Amputation	9.9%	555
Visual loss or impairment	5.1%	287
Deaf, without speech	1.7%	96
Deaf, with speech	3.0%	171
Other hearing impairments	2.6%	148
Speech impairment	1.9%	105
Mental illness	14.8%	828

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[1] BVR Annual Report Fiscal 1967-68.

Major Disabilities (Continued)	%	#
Personality, character, and behavior disorders	8.2%	460
Mental retardation or deficiency	11.7%	657
Allergic, endocrine, etc. disorders	2.6%	146
Neoplasms	.1%	7
Blood diseases, etc.	.3%	15
Epilepsy and other nervous disorders	3.9%	221
Heart and circulatory conditions	4.7%	262
Respiratory diseases	1.7%	96
Digestive system disorders	2.0%	111
Other disibilities	1.6%	90

Education Level at Acceptance	%	#
None	0.1%	5
1- 7 years	7.1%	398
8 years	9.5%	532
9- 11 years	24.1%	1,356
12 years	38.4%	2,155
13 and over	6.4%	364
Special Ed.	14.4%	806

Source of Support at Acceptance	%	#
Family and friends	54.0%	3,030
Own income	14.8%	829
Public assistance	6.0%	336
Other benefits and insurance	5.8%	326
Workmen's compensation	2.7%	154
Public institutions	7.9%	293
Social security disability insurance benefits	11.0%	617
Private relief agencies	0.3%	17
Not reported	0.7%	42

Jobs After Rehabilitation		
Professional, technical, and managerial	9.6%	540
Clerical and sales	19.6%	1,100
Service	22.0%	1,237
Agricultural and allied work	1.9%	106
Industrial occupations		
Skilled	10.0%	560
Semi-skilled	3.3%	187
Unskilled	20.5%	1,150
Sheltered workshops and vending stands	2.2%	121
Homemakers & unpaid family workers	10.9%	615

APPENDIX VI
SELECTED SOURCES OF STATISTICAL DATA

A. SAMPLE SURVEY

PROJECTION of NUMBER of DISABLED INDIVIDUALS in the STATE of WEST VIRGINIA

BVR CODE	DISABILITY	ESTIMATE[1]	1970[2]	1975[2]
10-11	BLINDNESS	2,604	2,599	2,669
12-14	OTHER VISUAL IMPAIRMENTS	14,846	14,815	15,215
20-22	DEAFNESS	2,865	2,859	2,936
20-22	OTHER HEARING IMPAIRMENTS	6,772	6,757	6,941
68	SPEECH IMPAIRMENTS	1,823	1,819	1,868
30-44	ORTHOPEDIC DEFORMITY WITH AMPUTATION	7,553	7,538	7,741
30-44	ORTHOPEDIC DEFORMITY WITHOUT AMPUTATION	72,668	72,517	74,477
50	MENTAL ILLNESS	13,023	12,996	13,347
53	MENTAL RETARDATION	11,981	11,956	12,279
61 (less allergies)	ENDOCRINE, METABOLIC and NUTRITIONAL DISEASES	24,483	23,434	25,092
62	BLOOD RELATED DISEASES	2,605	2,599	2,669
63	DISEASES of the NERVOUS SYSTEM	6,511	6,498	6,674
64 + 62	CARDIAC and CIRCULATORY DISEASES	48,445	48,345	49,658
65	RESPIRATORY DISEASES	19,274	19,233	19,753
66	DISORDER of the DIGESTIVE SYSTEM	8,074	8,057	8,275
67	DISEASES of GENITO-URINARY SYSTEM	6,251	6,238	6,406

PROJECTION of NUMBER of DISABLED INDIVIDUALS in the STATE of WEST VIRGINIA (Continued)

BVR CODE	DISABILITY	ESTIMATE[1]	1970[2]	1975[2]
69	OTHER UNCLASSIFIABLE DISEASES	10,679	10,657	10,944
	TOTAL	260,459	259,917	266,944

[1] Based on population of 1960, U. S. Census.

[2] Based on the population projection by Dr. Leonard Sizer, Rural Sociologist, University of West Virginia, in cooperation with the Office of Research and Development West Virginia Center for Appalachian Studies.

SUMMARY OF FINDINGS

The major finding to come out of the sample survey is that an estimated 260,459 state residents have either a physical or mental impairment. This figure represents 14 per cent of the total state population. About 13 per cent of the state's population, or 242,748 of these handicapped individuals, are 14 years of age or older.

Major Disability Categories

When three major disability classifications are used, we find that 206,544 state residents (79%) have physical disabilities such as orthopedic, cardiac, respiratory, and other functional impairments. Some 28,911 persons (11%) have sensory disabilities involving speech, vision, and hearing problems. The remaining 25,000 (10%) are psycho-socially impaired because of mental illness, mental retardation, and numerous emotional disorders.

The latter figure regarding psycho-social disabilities would appear to be conservative, since it represents only 1.3 per cent of the state's total population. National estimates have indicated that three per cent of the state's population, 55,700 individuals, are mentally retarded, and 10 per cent (186,000) are troubled by mental illness.

Two factors would serve to account for the rather large discrepancy between the survey findings and national estimates in regard to psycho-social disabilities. These include:

1. Many respondents (persons interviewed) are not sufficiently informed about psycho-social disorders and, consequently, may not recognize them even when present among family members. This is especially true in borderline cases.
2. There is a very definite stigma attached to mental illness and mental retardation, and many parents are reluctant to admit that someone in their family may be psycho-socially impaired.

These facts would suggest that other source materials and studies should be taken into account to determine more closely the number of West Virginians with psycho-social disabilities. If there is a weakness in the overall findings of the survey, this would have to be it. All other findings seem to be quite reliable.

From an overall study of the data, it appears that orthopedic, cardiac, and psycho-social impairments rank high in the incidence rate of disability in West Virginia.

Age Distribution

An analysis of the ages of the state's disabled population shown that 6.8 per cent, or 17,611 individuals, are below 14. Some 69.9 per cent, or 181,289, fall between the ages of 14 and 64. The remaining 61,468 handicapped state residents are 65 years of age and older.

Sex Distribution

Fifty-six per cent of West Virginia's handicapped population are males, while 44 per cent are females. Considering the sex breakdown in the state's total population (males - 49%; females - 51%), there appears to be a greater incidence of disability among males.

Education

Among the 260,459 disabled state residents, 30 per cent have high school educations, and six per cent have college or graduate training. The remaining 64 per cent range all the way from pre-school or no formal education to 8 years.

Employment

Only 30 per cent of the handicapped population, 14 years of age and older, are employed either full time or part-time. Seventy per cent are unemployed or retired. This indicates that there are 168,953 unemployed handicapped individuals over age 14 in West Virginia.

The occupational backgrounds of the 970 handicapped individuals turned up as a result of the survey are presented in the results section of this report.

Rehabilitation Potential

One aspect of the need determination calls for an evaluation of the handicapped individual to determine whether he could benefit from vocational rehabilitation services, and if

so, when. Based on the interviewer's evaluation, some 92,984 of the total 260,459 handicapped would appear to have good rehabilitation potential. An additional 116,686 were considered good future candidates.
(Primarily, those below age 14)

Two other questions in the survey attempted to develop information with respect to the demand for services for rehabilitation center or sheltered workshop services. The survey revealed that 74,491 persons are in need of, and could probably benefit from, rehabilitation center of sheltered workshop services.

Causes of Disability

It was also observed that 69 per cent of the state's disabled population incurred their handicaps as a result of various diseases. Sixteen per cent were disabled through accidents, and 15 per cent attribute their physical or mental impairments to birth defects.

Duration of Disabilities

More than 89 per cent of the disabled group have been handicapped for more than two years. Only two per cent had been disabled for less than six months. Thirty-seven per cent of the cases were adjudged as severe, 47 per cent as moderate, and 16 per cent as mild.

Agency Assistance

A very large number of the handicapped, 68 per cent, said that no public or private service agencies were providing any help to them when the survey was conducted January 15 - 22. (The names and addresses of some 346 immediate candidates have since been turned over to the State Division of Vocational Rehabilitation for follow-up by the Project Staff.)

About 59 per cent of the group, an estimated 143,353 persons, are experiencing difficulty in getting and holding jobs because of their disabilities.

Public Information

Among those interviewed during the course of the survey, some 21 per cent had never heard of Vocational Rehabilitation. Although 79 per cent did say they had heard of the program, only a portion were familiar with the type of services the agency provides to the handicapped.

Social Handicaps

An effort was also made through the survey to determine the number of West Virginians who are socially handicapped. Estimates from the survey revealed that 93,340 families, or roughly 325,000 state residents, would be considered socially deprived.

B. TELEPHONE SURVEY AND COUNSELOR FOLLOW-UP

______Office Number
Project 308
September, 1967

University Extension
The University of Wisconsin
Survey Research Laboratory

DISABILITY SURVEY: SCHEDULE

1. First, please give me the sex and age of everyone who lives in this household. Let's list them by relationship to the head of the family.

RELATIONSHIP TO HEAD	SEX	AGE
1) Head		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

2. Has anyone here ever been hospitalized for any serious illness which still affects him or her?
Yes No

3. Has anyone here ever been hospitalized for any serious accident which still affects him or her?
Yes No

4. Has anyone here ever had extended bed rest or an extended period at home because of some disability or illness (we haven't covered already)? (IF YES: Does this still affect him or her?
Yes No
(TO FORM)

5. Does anyone here regularly take medicine or drugs prescribed by a doctor for an illness or disability (we haven't already covered)?
Yes No

6. Does anyone here see a doctor regularly because of some ongoing illness or disability (we haven't covered already)?

7. Has anyone here seen a medical specialist, psychiatrist, or psychologist for either a psysical or mental condition (we haven't covered already)? (IF YES: Does this still affect him or her?)
Yes No
(TO FORM)

8. Does anyone here use an appliance such as braces, an artificial limb, a cane or crutch, a wheelchair, very strong eyeglasses, or a hearing aid?
Yes No
(TO FORM)

9. Has anyone here--either now or formerly--received insurance or benefits because of a disability--like disability income from insurances, social security or veteran's benefits, workmen's compensation, etc.?
Yes No
(TO FORM)

(CONTINUE ON BACK OF PAGE)

Interviewer:______________ Date:____________ Sample #:________

Next I'll read a list of physical or mental problems people can have. For each one, please tell me if anyone here has had this problem. (IF YES: GO TO FORM, THEN RETURN TO NEXT QUESTION)

YES NO

___ ___10. First, severe and recurring headaches?

___ ___11. Sharp chest pains?

___ ___12. Shortness of breath?

___ ___13. Frequent fainting?

___ ___14. Excessive nervousness?

___ ___15. Stuttering, or some other speech defect?

___ ___16. Emotional problem... such as easily becoming upset?

___ ___17. Nervous breakdown?

___ ___18. Neurosis, or some other psychological disability?

___ ___19. Problem drinking of alcohol?

___ ___20. Mental retardation, or trouble keeping-up in regular school classes?

___ ___21. Severe scars or other disfigurements?

___ ___22. Allergy or skin problems?

___ ___23. Rheumatic fever?

YES NO

___ ___24. Heart trouble, or high blood pressure?

___ ___25. Kidney, gall bladder, liver, stomach, ulcer, or other gastro-intestinal troubles?

___ ___26. Hernia or rupture?

___ ___27. Diabetes?

___ ___28. Emphysema, chronic bronchitis, TB, asthma, sinus, or other lung, or respiratory, or breathing troubles?

___ ___29. Cancer?

___ ___30. Polio?

___ ___31. Deaf or hard of hearing?

___ ___32. Blind in either eye, or a vision problem glasses cannot correct?

___ ___33. Cerebral palsy?

___ ___34. Epilepsy?

___ ___35. Problem in hand, foot, arm, leg, or back--any deformity, stiffness, or absence, including arthritis or rheumatism?

___ ___36. Unusual size--either too large, too small, too fat, etc.?

___ ___37. Overall weakness or other general health problem we haven't covered?

YES NO

___ ___38. Any other serious condition, disability, or illness we haven't already covered?

___ ___39. Any other difficulty in working by anyone here...anyone who is not properly employed for a reason not yet covered?

40. The final questions will allow us to interpret the results of this survey. First, what is the occupation of the household head?

---

41. What was the highest grade of school or year of college completed by the head of your household?
____(SCHOOL), or ____(COLLEGE)

42. Just so we can check on our sample--how many separate listings are there in your telephone directory for this telephone number?
Just one, or ____(#)
(SEE NEXT PAGE)

42a. Do all the people listed with this number have the same last name?
Yes No

(SEE NEXT PAGE)

42b. How many different last names are listed with this number? _______(#)
(SEE NEXT PAGE)

Interviewer: How many persons reside here whose normal activities are restricted and are between the ages of 14 through 70?

None (END INTERVIEW)

______ (#) ASK QUESTIONS BELOW FOR EACH OF THESE RESIDENTS.

A. The Survey Lab of the University of Wisconsin and other agencies are gathering detailed information on health problems and disability. This information is essential to planning for the most appropriate kinds of services for people with health problems and disabling conditions. You could make a valuable contribution to this important project if you would agree to a follow-up interview in your home at your convenience. All information that you give would be held in confidence. Would you like to do this?

YES_ (TO QUESTION B)

NO_ (TO QUESTION A1.)

A1. Since __________'s condition may limit work possibilities, (he;she) might benefit from the services of your state's Vocational Rehabilitation Program. There are no obligations and--if you approve--a counselor from the Vocational Rehabilitation Program would come to your home and discuss it. Would this be all right?

YES_ (TO QUESTION B)

NO_ (END, OR TO QUESTION C FOR NEXT PERSON)

B. What is the full name and address of __________?

NAME: __________ STREET ADDRESS: __________

CITY: __________ STATE: __________

DIRECTIONS FOR FINDING RESIDENCE, IF ON RURAL ROUTE: ______

____

____

(END OF INTERVIEW)

C. You also noted that (FILL IN) __________ has a condition which may limit work possibilities. Would you agree to a follow-up interview about ______ in your home at your convenience by a state Vocational Rehabilitation counselor?

YES_ (TO QUESTION Cl.)

NO__ (END OF INTERVIEW)

Cl. What is __________________'s full name? ________________________

(END)

DISABILITY FORM

QUESTION NUMBER: __________

1. Who in the household (was; did; had) this? (FILL OUT SEPARATE FORM FOR EACH PERSON IN HOUSEHOLD)

   RELATIONSHIP TO HEAD: ____________________ AGE: ___________

NOTE: QUESTIONS 2 AND 3 NEED NOT BE ASKED IF THIS INFORMATION WAS OBTAINED FOR THIS PERSON ON A PREVIOUS DISABILITY FORM.

2. What is ______________'s present condition or diagnosis?____

   ____

   ____

3. In what ways -- if any -- does or will this condition restrict ______________'s normal activity at home, or at work (or at school)?

   NONE, or

4. INTERVIEWER: IS THIS PERSON 14 THROUGH 70 YEARS OLD AND RESTRICTED IN SOME WAY?

   YES __

   NO __

   GO TO NEXT PERSON, OR RETURN TO NEXT QUESTION ON INTERVIEW SCHEDULE.

Interviewer: ______________________ Sample number: ____________

The University of Wisconsin
Regional Rehabilitation Research Institute

COUNSELOR FOLLOW-UP
INTERVIEW GUIDE

RRRI Reference Number for Subject: (1-5) ______________________

Name of Disabled Subject: ______________________

Name of Respondent: ______________________

Counselor-Interviewer: ______________________

Date: ______________________

Remarks: ______________________

____

____

____

____

____

PERSONAL DATA (the disabled subject) INTERVIEWER CHECK BOX

(6) Race: ☐ 1 white ☐ 2 Negro ☐ 3 Indian ☐ 4 Other, specify

(7) Marital Status: ☐ 1 Single ☐ 2 Married ☐ 3 Separated

☐ 4 Divorced ☐ 5 Widowed

(8-9) Number of dependents:____________________________________

(10-11) Highest grade of school completed__________________________

(12) Describe any specific job skills___________________________

(13-14) Primary source of support:

☐ 01 Current Earnings	☐ 02 Pub. Asst. Fed.	☐ 03 Workmen's Comp.
☐ 04 Annuity or Non-Disability Ins.	☐ 05 Family & Friends	☐ 06 Pub. Asst. No. Fed.
☐ 07 OASDI Benefits	☐ 08 Private Relief	☐ 09 Pub. Insti. Tax Supported
☐ 10 Other Disability Insurance	☐ 11 Disability or Sick Benefits	☐ 12 Other (explain)

(15) Work Status:

☐ 1 Competitive Labor	☐ 2 Self Employed (other)	☐ 3 Unpaid Family Worker
☐ 4 Sheltered Workshop	☐ 5 Bus. Entr. (Homebound)	☐ 6 Not Working-Student
☐ 7 Self Employed (Farmer)	☐ 8 Homemaker (Own Home)	☐ 9 Not Working-Other

(16) Previously accepted for VR services ☐ 1 yes ☐ 2 no

(17) Has the handicap ever caused him to stop working? ☐ 1 yes ☐ 2 no

(18) Is he having trouble now in finding or keeping employment for which he is potentially (with VR) capable? ☐ 1 yes ☐ 2 no

ESTABLISH PRESENCE OF A DISABILITY AS DEFINED BY VRA FOR ELIGIBILITY

(19-21) Major disability (describe)______________________________

(22) Cause: ☐ 1 accident ☐ 2 disease ☐ 3 birth defect

(23-24) Years with this disability (to nearest year, e.g., 0, 1, 2)______

(25-27) Secondary disability (describe)______________________________

(28) Cause: ☐ 1 accident ☐ 2 disease ☐ 3 birth defect

(29-30) Years with this disability (to nearest year, e.g., 0, 1, 2)______

(31-33) Other disabilities (describe)______________________________

(34-36) ______________________________

(37-39) ______________________________

(40) Assess overall level of disability; i.e., physical, mental, or emotional limitation or combination:

☐	1 none	☐	2 slight	☐	3 mild
☐	4 moderate	☐	5 severe	☐	6 very severe

(41-42) If none, terminate interview after determining reason for the referral and explaining below: ______________________________

____

ESTABLISH THE EXISTENCE OF A SUBSTANTIAL HANDICAP TO EMPLOYMENT:

(43) Assess his present limitations in getting and keeping appropriate and available employment (consider employability globally in terms of all client characteristics, viz: physical, intellectual, emotional, economic, social, motivation and job skills).

☐	1 none	☐	2 slight	☐	3 mild
☐	4 moderate	☐	5 severe	☐	6 very severe

(44) If none, or slight handicap to employment please explain but continue with interview through to its conclusions: ______________________________

____

(45-47) Weekly earnings: $___________

ASSESS FEASIBILITY AS DEFINED BY VRA FOR ELIGIBILITY, i.e., expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation.

(48) Feasibility for eligibility

☐ 1 clearly infeasible ☐ 2 probably infeasible ☐ 3 borderline feasibility ☐ 4 probably feasible ☐ 5 clearly feasible

(49) If clearly infeasible please explain; then continue interview.__________

____

(50) Extended evaluation under PL 333 would be needed to verify the above assessment. ☐ 1 yes ☐ 2 no

ASCERTAIN TYPE OF SERVICE THAT IS NEEDED FOR TOTAL REHABILITATION.

(51-52) _____ Check ALL indicated services

_____01. Extended evaluation under PL 333
_____02. Medical assessment
_____03. Psycho-social assessment
_____04. Vocational assessment
_____05. Surgery
_____06. Prosthetic appliance
_____07. Psycho-therapy
_____08. Other medical treatment
_____09. Prevocational adjustment training
_____10. Vocational training (including college)
_____11. Small business enterprise services
_____12. Maintenance and transporaation
_____13. Counseling - for vocational objectives
_____14. Counseling - for personal adjustment
_____15. Counseling - for job placement
_____16. Assistance in finding and getting job with routine follow-up
_____17. Follow-up services after placement continuing over an extended period
_____18. Rehabilitation center or workshop services including any of the above.
_____19. Other services, describe __________________________

____

(53) Estimate how long would be required to complete all above services (Check one).

_____1. under 6 months
_____2. 6 to 12 months
_____3. 1 to 2 years
_____4. 2 to 3 years
_____5. 3 to 4 years
_____6. over 4 years

DETERMINE DISABLED SUBJECT'S INTEREST IN AN APPLICATION TO THE VOCATIONAL REHABILITATION AGENCY

(54) Degree of interest in an application:

☐ 1 disinterested ☐ 2 rather ☐ 3 somewhat ☐ 4 rather interested

☐ 5 very interested

(55) If disinterested in service, give reason: ____________________

____

CHECK AND IDENTIFY VOCATIONALLY REHABILITATIVE SERVICES DISABLED SUBJECT HAS RECEIVED FROM OTHERS.

	Service Source	1. Now	2. Previously	3. Never	Describe Services
(56)	DVR				
(57)	DPW				
(58)	OASDI				
(59)	ST. ES				
(60)	VA				
(61)	Poverty Programs				
(62)	Self				
(63)	Family				
(64)	Other (Describe)				

(65-66) Type of services received from DVR. ____________________

(67-70) Type and monthly amount of Public Assistance: $________ Type__________

(71) Which of the above service sources were perceived as helping in subject's vocational rehabilitation process? (Circle item numbers)

1 2 3 4 5 6 7 8 9

DETERMINE IF ANYONE ELSE IN HOUSEHOLD IS A CANDIDATE FOR REHABILITATION SERVICES

(72) Another candidate(s) for rehabilitation services?

☐ 1 yes ☐ 2 yes, but already identified ☐ 3 no

Who is this person(s)?

Name____

Name____

COMPLETE ANOTHER SURVEY FORM (COUNSELOR FOLLOW-UP INTERVIEW GUIDE) FOR ABOVE PERSON(S)

KNOWLEDGE OF VR SERVICES

(73-74) Check how respondent first heard of vocational rehabilitation services.

_____1. This survey for the first time

_____2. Medical person

_____3. School

_____4. Government agency or official

_____5. Other professional person

_____6. Friend or relative

_____7. Newspaper, radio, TV

_____8. VR contact directly

_____9. Other (explain) ______________________________

____10. Don't know or don't remember

(75) Did interviewer personally observe disabled subject?

☐ 1 yes ☐ 2 no

(76-77) Length of interview: ____________min.

GA:VR C: GREENLEIGH SCHEDULE **CONFIDENTIAL**

Region Number:

______________ 2-5

OHIO VOCATIONAL REHABILITATION - STATEWIDE PLANNING

AGENCY SCHEDULE

Name of Agency:________________________ Phone:____________

Address:____ 6-8
(Street Number) (Street) (County)

Name and Title of Agency Administrator:

________________________ ____________
(Name) (Title)

Name and Title of Person Completing this Questionnaire:

________________________ ____________ 9-
(Name) (Title)

Date Completed:________________________

10 -1 Mail questionnaire________

-2 Interview________

(PERMISSION GRANTED)
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Greenleigh Associates, Inc.
New York Chicago San Francisco

Instructions: Please circle the response which most accurately completes the statement, e.g., if your response to a question is "no," please complete by circling the number in front of "no":

-1 Yes [✓ -2 No]

In some questions more than one number may be circled if multiple responses are applicable.

I. IDENTIFYING DATA

A. Your agency is classified as (multiple response permitted):

11 -1 Social service agency
-2 Hospital facility
-3 Extended care facility
-4 Mental health clinic
-5 Correctional setting
-6 Vocational training program
-7 Vocational rehabilitation center
-8 Employment service

12 -1 Educational agency
-2 Public welfare agency
-3 Public health agency
-4 Recreational facility
-5 Antipoverty program
-6 Sheltered employment
-7 Other, specify:______
____

B. Is your agency:

13 -1 Private
-2 Public
-3 Church-related
-4 Other, specify:______________________

C. Is rehabilitation a primary purpose of your agency?

14 -1 Yes -2 No

D. Your agency is located in:

15 -1 An urban area
-2 A suburban area
-3 A rural area
-4 Other, specify:______________________

E. Does your agency serve people from:

16 -1 An urban area
-2 An urban-rural area
-3 A rural area
-4 All of the above

F. Is your agency easily accessible by means of public transportation?

17 -1 Yes
-2 No

G. During the past fiscal year what was the total number of clients (patients, cases) your agency serviced?

18 -1 0-100
-2 101-500
-3 501-1000
-4 1001-2000
-5 2001-5000
-6 Over 5000

H. Your agency services:

19 -1 Adults
-2 Children
-3 Aged
-4 Various combinations of 1, 2 and 3 above
-5 Other, specify:__________________________

I. From the total client population,which is the major ethnic group served?

20 -1 White
-2 Negro
-3 Spanish-speaking (Puerto Rican, Cuban, Mexican)
-4 Other, specify:__________________________

J. From your present total client population which income group represents the majority of those being served? (family income)

21 -1 Under $3,000 per year
-2 $3,000 - $5,000 per year
-3 $5,001 - $7,000 per year
-4 $7,001 - $10,000 per year
-5 Over $10,000 per year

K. Does your agency have eligibility requirements in order for a client to be served

22 -1 Yes
-2 No

L. If yes, which of the following determine eligibility to receive service? (multiple)

23	-1	Age	-5	Residence
	-2	Sex	-6	Disability or handicap
	-3	Income	-7	Transportation
	-4	Religion	-8	Other, specify:_______

M. Are any services of your agency specifically oriented toward serving handicapped or disabled persons?

24 -1 Yes -2 No

N. If yes, what is your estimate of the number of people presently receiving services from your agency who are disabled?

25	-1	0-50	-5	501-1000
	-2	51-100	-6	1001-2000
	-3	101-300	-7	2001-5000
	-4	301-500	-8	Over 5000

O. Does your agency service any of the following types of disabilities? Please indicate by circling yes in Column I or no in Column II.

Disability	Yes I	No II
Visual impairment	26 -1	-2
Hearing impairment	27 -1	-2
Mental illness	28 -1	-2
Mental retardation	29 -1	-2
Speech impairment	30 -1	-2
Orthopedic impairment, except amputations	31 -1	-2
Cardiac and circulatory conditions	32 -1	-2
Respiratory diseases	33 -1	-2
Disorders of digestive system	34 -1	-2
Cancer	35 -1	-2
Alcoholism	36 -1	-2
Drug addiction	37 -1	-2
Amputee	38 -1	-2
Neurological, specify:	39 -1	-2
Social disorders	40 -1	-2
Correctional	41 -1	-2
Other, specify:	42 -1	-2

P. Does your agency have adequate facilities (ramps, handrails, parking, rest rooms, etc.) to handle the handicapped or disabled person?

43 -1 Yes -2 No

Q. Does the agency currently have a waiting list for clients needing service?

44 -1 Yes -2 No

R. If yes, what is the average number of clients awaiting admission for services?

45 -1 Under 25
-2 25 - 50
-3 51 - 100
-4 101 - 200
-5 Over 200

S. During the last year what is the average length of time a client has been on the waiting list?

46 -1 Less than one month
-2 One month, but less than three months
-3 Three months, but less than six months
-4 Six months, but less than nine months
-5 Nine months - 12 months
-6 More than one year

T. Do you assist handicapped people to receive rehabilitation services not provided by your agency?

47 -1 Yes -2 No

U. If yes, how do you assist them?

48 -1 Inform client of available community resources
-2 Make appointment for client with another agency
-3 Sharing of records with another agency
-4 Case conferences with another agency
-5 Other, specify:______________________________

V. Is there any follow-up to make sure they receive the service?

49 -1 Yes -2 No

W. Does your agency charge fees for services?

50	-1	Yes	-2	No

X. If yes, who pays for the services?

51	-1	The client	-4	Workmen's compensation
	-2	Bureau of Vocational Rehabilitation	-5	The union
			-6	Medicare or Medicaid
	-3	Insurance company	-7	Other, specify:__________

Y. What were your agency's total operating expenditures for the past fiscal year?

52	-1	Under $10,000	-4	$100,001 - $500,000
	-2	$10,000 - $50,000	-5	$500,001 - $1 million
	-3	$50,001 - $100,000	-6	Over $1 million

Z. For rehabilitation services to the disabled, what were your agency's total expenditures for the past fiscal year?

53	-1	Under $5,000	-4	$50,001 - $100,000
	-2	$5,001 - $10,000	-5	$100,001 - $500,000
	-3	$10,001 - $50,000	-6	Over $500,000

AA. Funds for such programs are received from the following (multiple):

54	-1	Federal government	-7	Earned income from agency programs or projects, specify: ______________________
	-2	State government		
	-3	Local government		
	-4	United Appeal	-8	Foundations
	-5	Bureau of Vocational Rehabilitation	-9	Contributions
			-0	Fees
	-6	Bureau of Services to the Blind	-x	Other, specify:__________ ______________________

Card II

Region Number: ____________ 2-5

II. SERVICES

Below is a list of community services that may be available to the disabled or handicapped person. Please indicate by circling in:

Column I - Which of these services are available at your agency?

Column II - For which of these services have you referred the handicapped person to another agency within the past year?

Column III - What services would you have referred clients to but were not available in the community?

	I Available at Agency	II Refer to another Agency	III Not available
A. General Services			
Casework counseling	6-1	-2	-3
Family counseling	7-1	-2	-3
Financial planning	8-1	-2	-3
Financial assistance	9-1	-2	-3
Housing	10-1	-2	-3
Employment	11-1	-2	-3
Legal	12-1	-2	-3
Day care	13-1	-2	-3
Homemaker service	14-1	-2	-3
Other, specify:	15-1	-2	-3
B. Medical Services			
Physical and medical evaluation	16-1	-2	-3
Physical therapy	17-1	-2	-3
Occupational therapy	18-1	-2	-3
Speech therapy	19-1	-2	-3
Audiological service	20-1	-2	-3
Prosthetic and other appliances	21-1	-2	-3
Dental	22-1	-2	-3
Other, specify:	23-1	-2	-3
C. Psychological Services			
Psychological counseling	24-1	-2	-3
Clinical testing	25-1	-2	-3
Psychiatric evaluation	26-1	-2	-3
Psychiatric treatment	27-1	-2	-3
Other, specify:	28-1	-2	-3
D. Vocational Preparation			
Vocational guidance and counseling	29-1	-2	-3
Vocational training	30-1	-2	-3
Job placement	31-1	-2	-3
Sheltered workshop	32-1	-2	-3
Work adjustment	33-1	-2	-3
Work evaluation	34-1	-2	-3
Basic education	35-1	-2	-3
Higher education	36-1	-2	-3
Other, specify:	37-1	-2	-3

E. From which sources do you receive referrals for vocational rehabilitation services provided by your agency? (multiple)

38 -1 Hospitals and clinics

-2 Physicians

-3 Self referrals

-4 Employment service

-5 Bureau of Vocational Rehabilitation

-6 Department of Welfare

-7 Schools

-8 Antipoverty programs

39 -1 Church and religious affiliations

-2 Social Security Administration

-3 Selective Service

-4 Unemployment compensation offices

-5 Correctional institutions

-6 Insurance companies

-7 Other, specify: ______________

III. MANPOWER

A. Below is a list of staff positions which may represent or be similar to the categories of personnel in your agency. In Column I please fill in the number of positions that are allocated in the budget. In Column II fill in the number of vacancies (if any) that exist at the present time. In Column III fill in the estimated staff needed in the next five years.

Staff Position	I Budgeted Positions	II Present Vacancies	III Estimated Need
	42-44	45-47	48-50
40-1 Director, administrator			
-2 Other administrative and supervisory personnel			
-3 Research staff			
-4 Physicians			
-5 Psychiatrists			
-6 Psychologists			
-7 Nurses			
-8 Occupational therapists (registered)			
-9 Physical therapists (registered)			
41-1 Speech therapists			
-2 Teachers and instructors			
-3 Vocational counselors			
-4 Rehabilitation counselors			
-5 Employment counselors			
-6 Social workers			
-7 Aides			
-8 Clerical personnel			
-9 Other, specify:			

B. In which of the following capacities are disabled persons involved in the agency?

51 -1 Program staff
-2 Maintenance and non-program staff
-3 Advisory committee
-4 Board
-5 Service volunteer
-6 Other, specify:________________
____
-7 None

IV. STAFF TRAINING

Does your agency provide for any of the following? Please indicate by circling Yes in Column I or No in Column II:

	Yes	No
Inservice staff training programs	52-1	-2
Inservice staff training programs in cooperation with other community agencies	53-1	-2
Special staff orientation programs concerning the rehabilitation of the handicapped	54-1	-2
Special stipends and/or released time for staff to obtain undergraduate degree	55-1	-2
Special stipends and/or released time for staff to attend graduate school in area of rehabilitation	56-1	-2
Joint efforts with other agencies to recruit rehabilitation staff	57-1	-2
Joint efforts with other agencies in order to interest young people to enter the rehabilitation field	58-1	-2
Special programs to use nonprofessional personnel as rehabilitation aides	59-1	-2
Participation in interagency efforts to identify needs in rehabilitation field	60-1	-2
Participation in interagency efforts to coordinate rehabilitation services	61-1	-2
Jointly plan programs to rehabilitate the handicapped	62-1	-2
Jointly plan research projects to rehabilitate the handicapped	63-1	-2

Card III

Region Number:____________ 2-5

V. RELATIONSHIP TO BUREAU OF VOCATIONAL REHABILITATION

A. Does your agency receive information directly from BVR about its program?

6 -1 Yes -2 No

B. During the past year has your agency made referrals to BVR?

7 -1 Yes -2 No

C. If yes, write in total number:____________ 8-11

D. Does your agency receive a report back from BVR on what happened to the people you referred?

12 -1 Yes -2 No

E. If yes, do you feel these reports are adequate?

13 -1 Yes -2 No

F. If no, how do you think they can be improved? Explain:____________

____________________________________ 14-

____________________________________ 15-

G. During the past year has your agency received referrals from BVR?

16 -1 Yes -2 No

H. If yes, write in total number:____________ 17-20

I. Does a BVR counselor visit your agency regularly?

21 -1 Yes -2 No

J. If no, would this service be of value to your agency?

22 -1 Yes -2 No

K. Has BVR paid for client services provided by your agency?

23 -1 Yes -2 No

L. If yes, what was the total amount received last year: $____________
24-28

M. Does your agency have any specific cooperative agreements with BVR?

29 -1 Yes -2 No

N. If yes. does your agency feel these agreements are satisfactory?

30 -1 Yes -2 No

O. If no, would you suggest ways in which agreements can be improved. Explain:

____

____ 31-

____ 32-

P. In the planning or implementation of programs for the handicapped does BVR provide consultation or technical assistance to your agency?

33 -1 Yes -2 No

Q. If no, would this service be of value to your agency?

34 -1 Yes -2 No

R. Has your agency found BVR able to provide those services necessary to rehabilitate the handicapped in your community?

35 -1 Yes -2 No

S. If no, would you please list any suggestions you may have for the improvement of the BVR program:

____

____

____

____

____

____

36-
37-
38-

VI. FUTURE PLANS AND SUMMARIZATION

A. Looking ahead to the next five (5) years, in which of the following areas does your agency have definite plans to develop or expand rehabilitation services?

39 -1 Building facilities
-2 Existing services
-3 New services
-4 Professional staff
-5 Nonprofessional staff
-6 Rehabilitation and counseling services
-7 Sheltered workshops

40 -1 Work adjustment services
-2 Interagency programs
-3 Cooperative programs with Bureau of Vocational Rehabilitation
-4 Special demonstration projects
-5 Research programs
-6 Other, specify:__________
-7 None (from the two columns)

B. Please summarize what you consider to be:

1) The major problems and needs of the disabled in the community:

____

____

____

____ 41-
42-

2) Suggestions as to programs needed to deal with rehabilitation of the handicapped:

____

____

____

____ 43-
44-

3) Types of programs or changes in patterns of services needed to deal effectively with the problem of rehabilitation:

____

____

____

____ 45-
46-
47-

APPENDIX VII

RIS ABSTRACTS: AN INFORMATION RETRIEVAL SYSTEM FOR COMPILING REHABILITATION LITERATURE

Bibliography

The selected bibliography listed following these appendices makes reference only to those specific documents consulted in direct relation to the preparation of this final report. Much information and data essential to the study has not been listed. It became apparent early in the Statewide Planning study that there was an immediate and on-going need for organized abstracts of rehabilitation concerned literature. In March, 1967, substantial proposals were developed by the Federal Region V planners and Mr. Earl Graham, Librarian, National Society for Crippled Children and Adults. With the assistance of Drs. George Wright and William Sather, a suitable plan was developed, and at the Region V Vocational Rehabilitation Planning Workshop held May 23 and 24, 1967, Illinois, Wisconsin and Ohio statewide planners committed " . . . their readiness and willingness to pursue the information retrieval system . . ."

Pilot Study

A pilot study was conducted to refine the project and to develop a set of parameters useful in categorizing rehabilitation literature. The immediate goal of the project was to prepare and disseminate to the participants 2,000 digests covering the most relevent rehabilitation related literature published since 1958. Each month, IBM cards, coded abstracts of the literature, and an updated reference bibliography (by subject) were received from the Regional Rehabilitation Research Institute at the University of Wisconsin, which was charged with developing the Information Retrieval System.

Abstracts Reference Library

On July 9, 1968, the last shipment of RIS abstracts was received. This shipment completed the set of approximately 2,000 digests of publications considered to be of most value in assessing the number of disabled persons and their service needs. The abstracts are now filed at the Statewide Planning Office in Columbus, where various methods of filing and retrieval, including punched cards, Uniterm cards, and magnetic tape, are being considered to insure maximum availability of these abstracts for use by rehabilitation staff members throughout Ohio.

Composition of the Retrieval System

The retrieval system consists of three main parts: One, a dictionary listing the criteria the abstractors used to categorize each article (and an appropriate set of code numbers). Two, a set of nearly 2,000 abstracts on 8½" x 11" paper filed in numerical order by document serial number. Three, a set of IBM cards on which document serial number and code numbers appropriate to the individual abstract have been punched.

The abstracts dealing with particular information are selected through the use of an IBM card sorter. By repeated sorting of the "accepted" cards on different columns (criteria) it is possible to select the one or two pertinent items from among the 2,000 abstracts in seconds.

The "intersection" of the sets of abstracts dealing with three categories is usually a fairly small number of documents that contain relevent information. Once the IBM cards have been "selected", the actual abstracts are located by document serial number.

Materials Included in the Abstracts

Of the 2,000 abstracts that have been prepared, the subject matter, though rehabilitation-oriented, may range from specific discussion of a disabling condition and functional impairment to general discussion of the philosophy and theory behind any given rehabilitation counseling practice. The broad range of topics covered in these materials makes it prohibitive to list even a portion of the abstracts here. For this reason, the bibliography given in this Appendix was restricted to those selected materials used directly in compiling the final report. However, the instructions given to those participating in the Information Retrieval System project may be helpful in identifying for the reader some of the criteria used in selecting printed materials and writing abstracts for this project. A sample RIS abstract is included, following these instructions.

UTILIZING THE RIS ABSTRACT

Selection of Articles

To determine whether or not an article should be abstracted for this project, the person selecting the articles will ask the following questions of each article being considered:

1. Does it discuss incidence and/or prevalence in the United States?
2. Does it describe services needed by specific groups of disabled persons?
3. Does it describe ways of delivering these services?
4. Does it assess the service or describe a method of assessment?

If the article serves any one of these needs, it must also fit the model.

Even if an article meets these criteria, we will not include it if it deals with:

1. Philosophy and theory
2. Services that do not refer specifically to a disability group or groups
3. Methods of medical diagnosis and treatment
4. Only children, except for incidence and prevalence studies
5. Nursing homes or other "care" for patients
6. Dictionaries and bibliographies

Writing the Abstract

The abstract is to be a slanted, substantive abstract, comprehensive and specific enough to give the planner the information he needs without his having to go back to the original source.

The identification of the source should be put at the top of the abstract in the following forms, which are used in Rehabilitation Literature:

Article: Author's Last Name, First, "Title of article." Publication. Month, Year. Volume: Number: Pages.

Abstract of a Research Report

1. Let the first sentence sum up the study, but do not repeat the same information given in the title.

2. Explain other specific purposes, questions, or hypotheses.

3. Describe the sample in the following terms:

   Size
   Age
   Sex
   Race
   Disabilities
   Other disabling conditions
   Any other characteristics of the total sample that provided a basis of selection

4. State the name and type of any instruments used.

5. Specify significant results, implications and conclusions the author draws in line with his purposes. If results are given in terms of raw numbers and percentages, report only the percentages. If he states the limitations of study, this may also be included.

Abstract of a Literature Review

1. State the reason why the author is reviewing the literature.

2. Give the conclusions he draws from the literature (but don't cite what specific references report).

3. At the bottom of the abstract, note the number of references the author cites. Example: (32 references cited)

Abstract of a Description of a Service

This type of abstract should contain:

1. A statement of the purpose of the document.

2. The name of the institution on which results are based.

3. Description of the persons on whom the technique was used.

4. A description of the techniques, including whether or not it is original to the author.

5. A description of the program; i.e., how the techniques are organized to achieve the purpose of the program and how long the process takes.

6. Conclusions the author draws from his experience with the program.

Abstract of a Book or Monograph

1. Give the overall purpose.

2. Copy the main headings from the Table of Contents.

3. Abstract each chapter as if it were a separate article, using the appropriate format given above.

General Guidelines

The following guidelines can serve to answer specific questions:

1. In the body of the abstract, cite all information that is coded. For example, if you code "age", in the abstract say what the article said about age.

2. Since it will add little, if any, additional length to the abstract, when you find a rate to quote, give the specific figure the author uses. For example, "46% of the population" is preferable to "about half". We realize that such a fine distinction is being extremely specific and that users of the abstract, when quoting it, will probably choose the more general description, but giving them the most specific figure will allow them to make the decision.

3. Initials of tests, organizations, etc., may be used if the first time you cite it you state the name in full with the initials in parentheses after; such as American Psychological Association (APA).

4. If more than one disability is mentioned, they are to be coded.

Coding

The model serves as the code. The abstractor is to give the appropriate codes on the left-hand margin of the abstract in the following form: If the article was published in 1966, he puts in the margin:

(6-7)
66

That is, the column is put in parentheses and the appropriate row is given directly under it.

Guidelines for Coding

1. Always code the following columns:

6-7: year of publication
8-9: reference source (11 for all references from the Library of The Society for Crippled Children and Adults)
72: type of article
73-80: identification

2. Code each disability mentioned in the article.

3. Code "speech and recreational therapy" under "physical restoration".

4. If you cannot decide whether a piece of information is more appropriate in one column or another, code it in both to insure against unnecessary loss of information.

5. Code a 1 in column 30 if you code any of columns through 42.

6. Code all variables used in the description of the sample.

SAMPLE RIS ABSTRACT

Rubin, Arthur. Therapeutic recreation services with the physically handicapped. Recreation for the Ill and Handicapped. July, 1966. 10:3:13-16, 23.

This describes the recreation program at the Rehabilitation Institute of Chicago. Today, 25,000,000 Americans, or 1 out of 7, are chronically disabled and have no time but leisure time. In four years, 1 out of 6 Americans will be chronically disabled; for these persons meaningful, productive, realistic, creative, and therapeutic recreation programs are needed.

At the Institute, the Therapeutic Recreation Department is an integral part of the rehabilitation team. Emphasis is given to the patient's freedom to choose, not only the activities in which he will participate, but whether he will participate at all. Many activities are offered simultaneously, and participation is urged, but never pushed. The approach is to "entice them to participate". The program operates seven days a week.

The primary concern is with the patient's resocialization, returning to participate in the community as an active citizen, not with game skills. Many out-trips to different social activities offered by the community are planned. Exemplary of these trips are shopping tours, trips to concerts and art exhibits, and outings to athletic events. When attending these out-trips, no specially equipped vehicles are used. Never will they learn how to transfer from wheelchair to car if they travel in specially equipped buses. Before discharge, patients are referred to community recreation centers and introduced to other recreational resources. The department helps community resources establish and manage programs for the handicapped.

To help dispense with the feeling of institutionalization, stress is placed on the inclusion of the able-bodied in all activities. Patients are encouraged to invite friends and relatives to participate in events. This mingling is also important in re-establishing patients' self-esteem and in dispelling self-consciousness at being seen publicly in wheelchairs and braces.

The most difficult group to reach recreationally are the middle-aged or older hemiplegics who besides suffering with paralysis are also afflicted with asphasis, which often includes not only an inability to speak intelligibly but also an inability to understand speech. A program adapted to their needs is provided. Incorporated in this program are group activities such as card playing (where they use figures which helps them learn to count again), and work games such as scrabble, which are designed to support their socialization process. Once a month they select a community activity to attend and during the summer, they are encouraged in activities (tea parties, for instance) where they entertain able-bodied guests--an important aspect in re-establishing self-esteem.

Initially the recreation program charged no fees, but gradually token payments (generally 25¢ and never more than $1.00) became necessary. This proved to be another means of re-establishing self-esteem and actually increased the number of participants.

It has been found that patients who, after discharge, become involved in community programs are less apt to seek readmission to the Institute, and at periodic check-ups, they are in better physical, mental, and emotional condition than those who do not participate. In a survey of older persons, actively participating in Golden Age Clubs and similar programs, there were 50% fewer visits to clinics and doctors' offices; 50% fewer hospitalizations, and 800% fewer mental breakdowns than among persons of the same age bracket not participating in active recreation programs.

A final advantage of this program is that by providing recreation for physically disabled persons the able-bodied family member who is caring for the person also is provided with time for recreation.

BIBLIOGRAPHY

A. Note of Explanation

The selected bibliography listed here includes only those works directly referred to in the preparation of this volume of the Final Report.

Not indexed are the seven other volumes of the Final Report which represent the findings, conclusions, and recommendations in each of the seven planning regions of the Ohio two-year study. These seven regional reports were basic to the writing of the statewide report, and copies are available to regional planners and to others who wish to study them.

In addition, over 2,000 abstracts of rehabilitation literature are on file with the Ohio Bureau of Vocational Rehabilitation. Although it is impossible to list them here in any coherent manner, these abstracts proved most helpful to researchers, and information and data from them was incorporated into this volume of the Final Report in various ways. Appendix VII indicates the nature of these abstracts in more detail, and includes a sample abstract as well as description of the project conducted in Federal Region V of the Rehabilitation Services Administration to make this information readily available to planners in the 5 states that comprise Region V.

B. Selected References

STATISTICAL DATA

Division of Statistics and Studies, Vocational Rehabilitation Administration:

Caseload Statistics: State Vocational Rehabilitation Agencies Fiscal Year 1967. Washington, D.C.: Government Printing Office, 1967.

Characteristics and Trends of Clients Rehabilitated in Fiscal Years 1963-1967. Washington, D.C.: Government Printing Office, 1968.

State Vocational Rehabilitation Agency Program Data: Fiscal Year 1965. Washington, D.C.: Government Printing Office, 1966.

State Vocational Rehabilitation Agency Program Data: Fiscal Year 1966. Washington, D.C.: Government Printing Office, 1967.

State Vocational Rehabilitation Agency Program Data: Fiscal Year 1967. Washington, D.C.: Government Printing Office, 1968.

An Exploratory Cost-Benefits Analysis of Vocational Rehabilitation. Washington, D.C.: Government Printing Office, 1967.

Economic Research Division, *Ohio Economic Outlook 1968*. Columbus, Ohio: Development Department, 1968.

Statistics in Vocational Rehabilitation. South Orange, New Jersey: Seton Hall University, n.d. (Proceedings of the Bi-Regional Statistical Seminar for Administrative Personnel, State Vocational Rehabilitation Agencies, Regions I and II, at Philadelphia, Pennsylvania, October 23-25, 1967.)

REHABILITATION: GENERAL

Community Rehabilitation Study of Cincinnati Metropolitan Area. Cincinnati, Ohio: Public Health Federation, 1967.

Dishart, Martin, Ph.D., *Vital Issues and Recommendations From the 1965 National Institutes for Rehabilitation Research*. Washington, D.C.: National Rehabilitation Association, 1965.

Gardner, John W., "The Renewal of Organizations," *Ohio Bell Bulletin for Management Employees: No. 8*, March 21, 1967.

Lewis, Irving J., "Some Reflections on Politics and Administration in Social Change," Address to the 1968 Spring Meeting of the Council of State Administrators of Vocational Rehabilitation. Washington, D.C.: May 1, 1968.

Margolin, Reuben J., Ed.D., "Impact of Social Systems Upon Rehabilitation of the Disabled," Delivered at the 11th Annual Tri-Organization Scientific and Clinical Rehabilitation Conference. Los Angeles, California: July, 1967.

Scurlock, Voyle, "An Evolving Administrative Practice for Vocational Rehabilitation Programs," Delivered at the Annual Conference of the National Rehabilitation Association. Denver, Colorado: October 5, 1966.

The State Federal Vocational Rehabilitation Program Looks to the Future: A Statement of Mission and Goals. Washington, D.C.: Council of State Administrators of Vocational Rehabilitation, 1967.

Whitten, E.B., "Principles Underlying Effective Joint Effort," Delivered at the National Conference on Alcoholism and Vocational Rehabilitation. Chicago: The University of Chicago Center for Continuing Education, January, 1965.

REHABILITATION: OHIO AGENCIES

Assessment of Agency Performance: Bureau of Vocational Rehabilitation, Department of Education; Bureau of Services for the Blind, Department of Public Welfare. Boston, Massachusetts: Harbridge House, Inc., 1968.

Ohio Workshops and Rehabilitation Facilities: First Year Project Report and Interim Plan. Columbus, Ohio: Bureau of Vocational Rehabilitation, 1967.

State Plan for the Administration of the Program of Vocational Rehabilitation in Ohio as Revised July 1, 1966. Columbus, Ohio: State Board of Education, 1966.

Study of State-Level Interagency Coordination in Relation to Vocational Rehabilitation in the State of Ohio. New York: Greenleigh Associates, Inc., 1968.

Survey of the Ohio Bureau of Vocational Rehabilitation. Washington: Office of Vocational Rehabilitation, U.S. Department of Health, Education and Welfare, 1957.

REHABILITATION: THE PROVISION OF SERVICES

Areawide Planning of Facilities for Rehabilitation Services: Report of the Joint Committee of the Public Health Service and the Vocational Rehabilitation Administration. Washington, D.C.: Government Printing Office, 1963. (PHS Publication No. 930-B-2. Participating Agency: Association of Rehabilitation Centers, Inc.)

Coffman, Ben, Joe Dusenbury, Robert Davis and John Webb, "Summary Group III: Workshop on Agency Problems in Manpower Development." Proceedings of VRA Seminar on Manpower Development, University of Oklahoma: 1967.

Harding, George T., Sr., M.D., Chairman, and Herschel W. Nisonger, Associate Chairman, Comprehensive Community Mental Health Planning In Ohio 1963-1965. Columbus, Ohio: Final Report of the Citizen's Committee, 1965.

Moriarty, E.J., Director, Bureau of Vocational Rehabilitation and Denver L. White, Director, Department of Public Welfare, An Agreement Between the Department of Education, Bureau of Vocational Rehabilitation, and the Department of Public Welfare. Columbus, Ohio: May 29, 1968.

Richardson, William P., M.D., "Interagency Coordination—A Basic Need in Serving Handicapped Children," *Rehabilitation Literature*, Vol. 27 No. 7, July, 1966. Copies available: Reprint AR-197; National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago, Illinois.

"Title 45: Public Welfare; Chapter IV," *Federal Register*, Vol. 31 No. 9, January 14, 1966.

"Vocational Evaluation and Work Adjustment Program," *Public Law 90-391 (Sec. 15(a)*, July 7, 1968.

FACILITIES AND WORKSHOPS

Office of Juvenile Delinquency and Youth Development, *Neighborhood Service Centers*. Washington, D.C.: Government Printing Office, 1967.

Recommendations for a Comprehensive, Multi-Disciplinary, Vocational Rehabilitation Center in Maryland. College Park, Maryland: Bureau of Educational Research and Field Services, University of Maryland, 1966.

Standards for Rehabilitation Centers and Facilities. Evanston, Illinois: Association of Rehabilitation Centers, Inc., 1965.

DISABILITIES

Aging

Margolin, Reuben J., and George Goldin, Editors, *Dynamic Programming in the Rehabilitation of the Aging*. Boston, Massachusetts: Northeastern University, 1967.

Project RD-903-P Final Report:
Volume I - Rusalem, Herbert, Ed.D., Roland Baxt, and Irving Barshop, *Rehabilitating the Older Disabled Worker*;
Volume II- Rusalem, Herbert, Ed.D., *The Vocational Adjustment of the Older Disabled Worker: A Selective Review of the Recent Literature*;
Volume III- Rusalem, Herbert, Ed.,D., Roland Baxt, and Irving Barshop, *The Vocational Rehabilitation of Neighborhood-Bound Older Disabled Persons: A Program Guide*. New York: Federation Employment and Guidance Service, 1967. Project RD-903-P was supported, in part, by a research and demonstration grant from the Vocational Rehabilitation Administration.

7A

Social Disabilities

Alcoholism and Vocational Rehabilitation. Washington, D.C.: Government Printing Office, 1966. (Proceedings of Workshop, North American Association of Alcoholism Programs and Vocational Rehabilitation Administration, Chicago, Illinois: January 6-7, 1965.)

Wiener, Frederick and Keith Turkington, "Job Placement of Addicts Through a Halfway House," *Rehabilitation Record*, January-February 1967.

"Correctional Rehabilitation," Rehabilitation Record, July-August 1967.

Department of Mental Hygiene and Correction, *Annual Report, Ohio Adult Parole Authority: July 1, 1965-June 30, 1966*. Mansfield, Ohio: Ohio State Reformatory Press, 1966.

Effective Approaches to the Rehabilitation of the Disabled Public Offender. Boston, Massachusetts: Northeastern University, 1966. (Curriculum Materials developed from a Conference May 10-12, 1966, Co-sponsored by the Department of Rehabilitation and Special Education, Northeastern University, and University College, in collaboration with the Vocational Rehabilitation Administration.)

Federal Bureau of Prisons Statistical Report Fiscal Year 1966. Washington, D.C.: U. S. Department of Justice, 1967.

Personal Characteristics and Parole Outcome. Washington, D.C.: Government Printing Office, 1966.

"Rehabilitation and the Public Offender," *Rehabilitation Record*, November-December 1965.

Rehabilitation of the Young Offender: A Cooperative Program of Correctional Rehabilitation. Oklahoma: Vocational Rehabilitation Service and State Reformatory, April 1967. (Final Report of a Research and Demonstration Project supported in part by a grant from the Vocational Rehabilitation Administration.)

Wolfgang, Marvin E., "The Culture of Youth;"
and Studt, Elliot, "The Reentry of the Offender into the Community."
Studies in Delinquency. Washington, D.C.: Government Printing Office, 1967. (Reports of the Office of Juvenile Delinquency and Youth Development.)

REHABILITATION-RELATED MATERIALS

Cities in Crisis: The Challenge of Change. Washington, D.C.: Government Printing Office, 1967.

Cohen, Wilbur J., "Social Policy for the Nineteen Seventies," Health, Education and Welfare Indicators, May, 1966. (Published periodically by the Department of Health, Education and Welfare.)

"Having the Power, We Have the Duty," The Advisory Council on Public Welfare, Report to the Secretary of Health, Education and Welfare. Washington, D.C.: Government Printing Office, June 29 1966. (Summary of Recommendations.)

Irelan, Lola M., Ed., Low Income Life Styles. Washington, D.C.: Division of Research, Welfare Administration, n.d.

Page, Harry O., A New Direction for Public Welfare. New York: Community Research Associates, Inc., 1961.